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ABSTRACT

The document contains papers from an interdisciplinary seminar on collaboration between medicine, education, and social welfare in the interests of the handicapped child. Section I contains 12 papers focusing on parent involvement; an historical review of treatment; medical, educational, and social welfare viewpoints; viewpoints on the legal interests of the child; viewpoints on the adequacy of legislation relating to children; and etiology and treatment of handicapping conditions in children. Section II includes 12 papers with the following titles: "Health, Education and Welfare--Guidelines for the Future;" "Medical, Educational, and Welfare Research Needs in the Education of Children;" "Normalizing the Experiences of Handicapped Children;" "Educational Programs for Children in Residential Care;" "Early Intervention and Handicap;" "The Role of Health Services in Schools;" "Homebound Children;" "Prosthesis in Educational Intervention;" "Handling Skills for Promoting Psychomotor Development;" "Problems of Deaf Children in Regular School;" "Teaching Children in Hospital;" and "The Role of the Psychologist in Meeting the Needs of Children." A final section with three papers provides perspectives for the future. (SBH)

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THE HEALTH, EDUCATION AND WELFARE OF CHILDREN

proceedings of an interdisciplinary seminar

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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Edited by:

Kathleen J. Cochrane

and

Robert J. Andrews

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Fred and Eleanor Schonell Educational Research Centre,
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INTRODUCTION

In the eight years that the Schonell Educational Research Centre has been organizing and conducting seminars into various aspects of special education, it has always been the Centre's aim to look at special education from a different vantage point each year. On this occasion, we believe we have achieved a fresh and broader perspective on the problems confronting exceptional children by involving, at the organizational level, the disciplines of Medicine and Social Welfare as well as Education. One of the outcomes of organizing the seminar on this broader professional base was the inclusion of twelve working parties in the program. These Working Parties enabled parents, teachers, foster-parents, paediatricians, nurses, physiotherapists, child psychiatrists, special educators, speech therapists, psychologists, members of various other professions, and members of voluntary organizations to come together in an atmosphere conducive to a mutually productive interchange of ideas - as well as to a free expression of criticism and grievance. More will be said about the organization of these Working Parties and the manner in which their findings have been reported in the special introduction to Section Two of this publication.

The Eighth Annual Seminar in Special Education was, without doubt, a resounding success. It was very well attended and expressions of appreciation were sufficiently abundant to gratify the organizers. Some special acknowledgements are obviously due, and should be made forthwith.

In the first place, the Honourable the Minister for Education was not only willing to perform the official opening of the seminar; he was also kind enough to allow the editors to use the speech he made on that occasion as a Foreword to this publication.

It must also be acknowledged that much of the success of this seminar is due to the time, the ideas and the practical help given by Dr. Simon Latham, Mr. Pat Briody and Mr. Robert Plummer. Without their suggestions as to Where, Who and How, this seminar could never have run as smoothly as it did.

Instead of that hackneyed phrase, "last but by no means least", let us in all justice acknowledge, first, last and for the duration of the seminar, the huge contribution of Miss Heather McDonald, Principal of the Hospital School, Royal Children's Hospital. It was on these new and beautiful school premises that many of the activities encompassed by the Eighth Seminar took place. And these included the many excellent displays mounted by special schools and voluntary organizations.

Not all papers presented during the Eighth Annual Seminar are included in this publication. A notable omission is the excellent paper presented by Dr. Robert Godfrey, F.R.A.C.P. It was felt by the editors that this paper should more properly be published, in the first instance, by a paediatric or other medical journal; for the emphasis of this particular paper was hospital-medical, and it was primarily addressed to an audience of paediatricians and arranged by the Paediatric Society of Queensland. Two other papers, each contributing to one-third of two different plenary sessions do not appear because the authors' approved manuscripts had not been received at the time when it was felt absolutely necessary to go to press.

Editing papers presented at a seminar in which the disciplines of Medicine, Social Welfare, Law and Education are all represented, in no easy task. If we are to preserve the flavour of a multi-disciplinary exchange of ideas, then we must also preserve something of the different styles and different conventions which each discipline brings to its mode of reporting. We hope we have done this in such a way as to produce a document which is continuously readable while not forcing all contributors into the educational-psychological mould that is the most familiar form of reporting to the editors.

The presentation of these proceedings was contributed to in no small way by Wendy Barrie, who undertook the task of preparing the drafts and expertly typed the manuscript in its final form.

KATHLEEN J. COCHRANE

ROBERT J. ANDREWS

FOREWORD

The Hon. V.J. Bird, M.L.A.,
Minister for Education and Cultural Activities

This is the Eighth Annual Seminar conducted by the Fred and Eleanor Schonell Educational Research Centre and is a collaborative venture between the Department of Education, the Royal Children's Hospital and the Schonell Centre.

The theme chosen for this Seminar is "Children: Health, Education and Welfare". In line with this theme the Seminar Program includes representatives of the fields of health, education and welfare from government departments, the University of Queensland, voluntary organizations, and the community at large.

The venue for the seminar, the recently-opened Royal Children's Hospital school, is particularly appropriate because it is a perfect example of multi-disciplinary cooperation. The school, which was officially opened just three weeks ago, was from the beginning a joint planning effort between the Royal Children's Hospital and the state departments of health and education.

Whilst perusing the seminar program I noted that the papers to be presented focus strongly on collaboration between medicine, education and social welfare in the interests of the children. Respective points of view will be presented by eminent leaders in their fields and it is my hope that as a result of this seminar the major impetus given to interdisciplinary approaches to community problems will permeate throughout the activities of all individuals and organizations participating in this seminar.

As my colleague, Dr. Edwards, stated during his address at the opening of the Hospital school, it is so easy to forget the total interests of the child when one is caught up in the flurry of professional activity. Whether one is involved in the field of health, education or welfare, it is heartening to remind ourselves of the total needs of the child. During this Seminar, Mrs. Quentin Bryce addressed herself to the topic "In Law, the interests of the child shall be paramount". The same philosophy needs to be continually applied in all avenues of public service so that it may truly be said:

- in Medicine, the interests of the child are paramount;
- in Education, the interests of the child are paramount; and
- in Social Welfare, the interests of the child are paramount.

I was particularly pleased that the first keynote address, delivered by Dr. Mitchell highlights parent involvement in the health, education and welfare of their children. It has long been my belief that

parents have a key role in the habilitation and rehabilitation of children. As Minister for Education, I have actively encouraged the participation of parents in school activities at all levels from pre-school through to further education.

One of the major challenges facing the Division of Special Education within my department is the provision of suitable education for all children who are able to be educated from the age when diagnosis of educational problems is possible. This is a massive undertaking which has been accepted in principle at this stage. It is an undertaking which can only be effected in collaboration with other government departments such as health and children's services and with approved voluntary organizations who are currently providing special education.

Some people actually argue that special education is a luxury we cannot afford, or even that it is a waste of time. In times of stringent financial conditions, it would be easy to slash programs for minority groups such as the handicapped to make more funds available for regular schools.

But those who have witnessed the joy of achievement on the face of a learning disabled child when he is able to read his first sentence or the physically handicapped child who is able to write her first sentence, would argue strongly and quite properly, in my view, that investment in special education not only brings human dignity to the handicapped, but also gives every child the opportunity to reach his full potential as a human being, which after all is the inalienable right of each one of us.

In the case of the severely handicapped, the result of education may simply be that the handicapped adolescent is self sufficient in feeding, toileting and dressing. Even at that level the cost-effectiveness of special education is much greater than the cost of custodial care, which would be necessary for the rest of his life if he was deprived of educational intervention during childhood.

For children with less severe handicaps, the pay-off to the community for the investment in special education is even more evident and rewarding for those who are able to observe the satisfaction from achievement experienced by handicapped children who have been assisted to become productive citizens. In this total regard I want to commend my colleague, Dr. Edwards, for his initiative in training residential care personnel for the severely handicapped.

I understand that medical evidence clearly indicates the higher incidence of suicide, depression and family breakdown among parents of the handicapped. It is in this area that the support services and social welfare agencies in addition to appropriate medical and educational provision become imperative. Again the team approach to solving the problem at the family and community level as well as individual casework is essential.

Every member of the community has a responsibility to lend support to the interests of the handicapped, to go the extra mile to help those less fortunate than ourselves. I have been delighted by the cooperation received to date from government agencies, schools, business houses, and community groups in fostering the aim of the division of special education in my department of integrating the handicapped wherever possible in education, in the community and in employment. We have done well but we still have a lot to achieve together, particularly for the more severely handicapped.

In the program, working parties were engaged in numerous areas of particular concern regarding handicapped children. The aim of the working parties was to look in depth at the specific issues from a range of viewpoints and to formulate recommendations for future action. Some of the topics for the working parties provided for a fresh look at continuing problems. Other topics reflected new developments such as programs for homebound children.

I am sure my colleagues, Dr. Edwards and Mr. Herbert, look forward, as I do to reading the recommendation of this week's cooperative deliberations by experts on the health, education and welfare needs of handicapped children.

We already have a number of special education ventures in which our departments work in close cooperation - these include the Hospital schools (Royal Children's, Mater Children's, Ipswich, Toowoomba and Townsville), the Tennyson Special School, the Guidance and Special Education Branch with the Central Assessment Clinic and Child Guidance Clinics, while the Department of Education and the Department of Children's Services work together in providing for the Outlook Special School, Boonah, the Kalimna Training Centre for Girls, and child care officers.

Finally, I want to assure you that the government is interested in the results of your discussion of legislation relating to children, particularly if changes can be made to protect the rights of children.

SECTION ONE

PLENARY PAPERS

CHAPTER 1

First Keynote Address

PARENT INVOLVEMENT IN THE HEALTH, EDUCATION, AND WELFARE OF THEIR CHILDREN

D.R. Mitchell

I face this address with some trepidation since I am aware that it is only two years since my friend and colleague, Professor Peter Mittler from the Hester Adrian Research Centre, addressed a special education seminar here in Brisbane on a similar theme. I am also aware that Professor Betty Watts is an advocate of some of the positions I wish to commend to you and that, no doubt, many of you know of her work in this area. Furthermore, I have, in part, 'stolen my own thunder', for an article I have written on this topic has just been published in the latest issue of *Rehabilitation in Australia.**

Be that as it may, there are various issues to do with the parent-professional partnership that I should like to bring to your attention, initially by posing five questions to you:

1. How well do you know the parents of the children for whom you have responsibility?

2. Have you observed them interacting with their children?

3. Do you keep parents accurately informed on the precise features of their children's progress?

4. Have you helped parents acquire specific skills in handling their children?

5. Do you give parents opportunities to suggest goals and methods?

My attitude towards these questions will become clear in the course of this lecture, but let me say from the outset I am advocating that professionals who deal with handicapped children should see themselves as partners of parents in providing the best environments for handicapped children.

I think it is salutory to remind ourselves from time to time that our various professions have not been around all that long. Relative to our long history, the broad mass of people have had free access to schools,

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* Parts of this lecture are based on: D.R. Mitchell, Special Education, families and the handicapped, an interactional view, *Rehabilitation in Australia*, 1977, 14(2), 16-19.

health, and social welfare agencies for only a brief period. And, as we well know, the rights of handicapped children for an education are only just being recognised, even in some so-called developed societies.

Viewed from this perspective, it is clear that for most of our history, we have relied upon means other than formal institutions such as the school to socialise our young into the beliefs, knowledge, and skills of our particular societies. I refer, of course, to the family. While I have no wish to turn the clock back to the archaic days when neglect and ill-treatment was the lot of the handicapped person, or their families received no assistance, I do want to stress that even in relatively sophisticated societies, the family is still the primary agency for socialising the young.

It is timely that the importance of the family be stressed right now for two reasons. Firstly, I fear that the quantitative and qualitative increase of services for the handicapped creates the real risk of parents of handicapped children abdicating their responsibilities. There is a dangerous trend for parents to place their trust in the professional, and, correspondingly, for the professional to perceive himself or herself as having extraordinary, exclusive skills. Unless we are careful, this will place barriers between those whose skills should be combined in the interests of children. The second reason for the timeliness of considering the role of the family in socialising the handicapped, is the increasing pressures parents face to retain the handicapped child in the family, in the community. In my view, society has an obligation to provide the necessary assistance to families to help them in their discharge of this responsibility.

While most professionals who deal with handicapped children would probably accept the view that the family plays an important role in mediating between the handicapped child and his broader environment, I question whether its full implications have been realised in the design of education, health, and welfare services. Since my main background and interests are in special education, I will focus my remarks on that area. But I do hope that a good deal of what I have to say is of relevance to those of you from social welfare and health agencies and even from general education.

In the remainder of this address, I should like to focus on two main topics :

1. The Role of the Family.
2. Programmes of parent involvement.

The role of the family

How, then, should the role of the family in special education be taken into account and how can it be augmented?

As I see it, special educators view the families of handicapped children in a variety of ways: Some have a vague appreciation that parents have an important role to play, but they are not quite sure what it is, or what they should do about it. Into this group fall those who are thrown into a state of bewilderment or even anxiety, when confronted by parents who wish to be consulted about or involved in their children's education.

A second group comprises those special educators who view parents in a negative light, perhaps finding them convenient scapegoats for their own inadequacies. This group also contains those who complain about some parents as being obstacles to the implementation of their teaching programmes. It also comprises those who have rigid notions of what constitutes the 'correct' approach to educating children and who find difficulty in accepting that parents may well have different strategies or even different goals. They rarely seek contact with the families of handicapped children or, when they do, the communication is so dominated by a status-differential as to be non-productive or even counter-productive.

The third and "ideal" group of special educators - and I do believe that some do fall into this category - take account of two main principles: Firstly, they accept the view that *the family is an integral part of the total system of special education.* They would accept that links must be established between parents and the various agencies that have been delegated by society, or by the parents themselves, to educate and care for the handicapped child.

These links must be -

regular : Ideally, there should be direct or indirect contact on a daily basis for young children and at least weekly for older children. This may take the form of face-to-face consultations in the home and/or the school, or it may be limited to telephone conversations or the exchange of messages in a diary that accompanies the child. Acceptance of this principle means that professional personnel must be provided with the facilities and the time to engage in regular consultation with parents.

two-way : It is very important for parents and professionals to see themselves as partners in the planning and implementation of programmes for handicapped children. While parents generally are reasonably receptive to the advice of professionals, I am afraid the reverse is not always the case. This is unfortunate, for many parents can offer professionals valuable insights into the behaviour of their children and into ways of handling them. To place them in the role of passive recipients of advice would not only be presumptuous but it would be to cut oneself off from insights and abilities gained, in many cases, after deep thought and intelligent experimentation over several years. Unless there

is good reason to believe otherwise, they must be viewed as skilled participants in the education and care of their children and they should be actively involved and accurately informed about all aspects of their children's development. By being open to ideas, there is much that professionals can and must learn from parents.

effective : Emerging from the previous point is the responsibility on professionals to develop ways of effectively transmitting and receiving ideas to and from parents. When this process breaks down, this is less a justification for berating parents than for critically examining one's own communication skills. To be realistic, however, it is clear that not all parents are able or willing to take advantage of even the best-managed opportunities. No matter how hard one tries, there will always be a residual group which will resist the notion of partnership. The aim should be to minimise this group.

Furthermore, within this total system, the parents should have full and meaningful opportunities to take part in the decision-making process. This point was well expressed in *Futures of Children* (1975), the final report of the Project in Classification of Exceptional Children, commissioned by the U.S. Department of Health, Education, and Welfare:

> "All federal, state and community programs that provide funds for services to exceptional children should require that parents (and whenever appropriate, young people themselves) have an effective voice in the design, conduct, and evaluation of the program. Professional and voluntary organisations concerned with exceptional children should make the empowerment of parents a high-priority objective of their programs" (p.30).

Indeed, there is now a law in the United States (Public Law 94 - 142) that requires parents and teachers to cooperate in planning and developing educational programmes for handicapped children. Although I have no knowledge of the extent to which this law is being implemented, its existence is clear testimony to the recognition in the United States of parents' moral, ethical, and legal obligations and rights to be actively involved in the education of their handicapped children.

To summarize so far, then, my point is that for the majority of handicapped children, the family is the primary socialisation agent. To ignore it or to work in competition with it, can only dilute or subvert the worth of the special education provided in schools and clinics. As I have suggested, acceptance of this view of the critical importance of family has radical implications for the structure of special education, for the roles of special educators, and, of course, for the way in which special educators are prepared for that role. This should not be seen as a diminution of the importance of the special educator but rather as a shift in emphasis away from his/her traditional role into a much more demanding - and ultimately more rewarding - role.

Having dealt at some length with the notion that the family should be viewed as an integral part of the total system of special education, let us turn now to the second - and related - requirement for a soundly-based programme of family involvement in special education. It is simply this: *any attempts to modify the behaviour of the handicapped child should be directed at the family as far as possible.*

Teachers, psychologists, and others concerned with the optimal development of handicapped children should be as much concerned with working with parents as with children. They should be designing programmes for parents to use, thus meeting the needs of parents such as the mother of a six-year old Down's syndrome child I talked to in Manchester:

> "You don't know what to do for them. There's not enough information given to us to help them. If we knew a bit more about a child like Paul we could help him more."

Programmes of Parent Involvement

In recent years, there has been a dramatic upsurge of programmes directed at training parents to become more effective in the education and care of their handicapped children. A number of these which have emphasized the role of parents as behaviour modifiers have been reviewed by writers such as Berkowitz and Graziano (1972), Johnson and Katz (1973), Nay (1975), and O'Dell (1974). Still others have emphasized training in play techniques (Jeffree, McConkey and Hewson, 1975), engaging in a task or skill-oriented training programme (Bricker and Bricker 1973), using resource kits (Cohen and Gloeckler, 1976, and Riedell, 1974). It is of course, beyond the scope of this lecture to summarise all these studies; there are ten programmes, however, which I should like to bring to your attention, some because of their local interest in Australasia, and some from England and U.S.A. because of their important contributions to developments in this field.

1. *The Portage Project, Wisconsin* (Shearer and Shearer, 1972). Commencing in 1969, this project is a home-based teaching programme serving a rural area and directed at involving parents in the education of their preschool children (0 - 6 years, mean IQ of 75) identified as having significantly delayed development in the areas of motor, self-help, social, language, or cognitive behaviours. Its main strategy involves "teaching parents what to teach, how to teach, what to reinforce, and how to observe and record behaviours." Home educators visit each family for 1½ hours per week to help parents implement a method of "precision teaching" in which specific behavioural goals are selected for the child to learn during the week, baseline data are recorded, and parents are given guidance in the form of minutely detailed written instructions on how to help the child achieve particular goals. Emphasis is placed on the need for parents to keep detailed records of the child's achievements, and the home educators carry out regular probe tests to determine if the prescribed skills have been learned.

2. *Down's Syndrome Project, Model Preschool Center for Handicapped Children, University of Washington, Seattle* (Hayden and Haring, 1974). This project began in 1971, initially with Down's syndrome children between 18 and 36 months, but was subsequently extended to cover children up to the early primary school level. The principal goals of the programme are to develop and use sequential programmes for increasing the children's rate of developing motor, communication, social, cognitive, and self help skills and to bring the children's developmental patterns as close as possible to normal children's developmental norms.

An important feature of the project is the training of parents to carry out the programmes designed for their individual child. This is achieved by means of supervised observations and other practical work, guided reading, regular discussions with the professional personnel, viewing films, videotapes, and tape-slide presentations, meetings with other parents, and regular participation in the classroom programmes by acting as teacher aides and data-gatherers.

3. *PIP (Parent Involvement Project), Hester Adrian Research Centre, University of Manchester* (Jeffree, McConkey, and Hewson, 1975). This project evolved, in part, from experience with workshops for parents of handicapped children (Cunningham and Jeffree, 1975). The workshops took the form of a combination of lectures and small group tutorials, the latter permitting greater flexibility in adapting to individual family differences. Workshops were aimed at helping parents to make more accurate and objective assessments of their child's skills and to gain an understanding of principles which will help them change behaviour and develop skills for this, and in the subsequent development of an early intervention project, emphasis is placed on parents acquiring a teaching model incorporating:

a. observation and assessment, using developmental charts as a guide;

b. selection and analysis of tasks, in which objectives are set and a relevant task is selected and broken down into a series of small steps;

c. presentation of task, in which favourable learning conditions are covered; and

d. evaluation of the child's progress by observation and simple testing.

4. *Down's Syndrome Project at Macquarie University* (Thorley *et al.*, 1976). This experimental project commenced in 1975 as an exemplar of a programme of early intervention for Down's syndrome children in

the years 0 - 5. The basic strategy of the project entails:

> a series of programming efforts directed towards establishing behaviours in highly controlled, one-to-one, instructional environments, then transferring them to less controlled classroom environments, and finally transferring them into the home via a parent training programme...
>
> The objectives of the latter include:
>
> a. keeping parents informed of the programme;
>
> b. instructing them in behavioural techniques;
>
> c. helping them know and understand the objectives of the curriculum;
>
> d. helping them know the goals to which their own child is working;
>
> e. providing opportunities to share their problems with other parents of Down's syndrome children.

Both parents are expected to attend two nights a term for parent training sessions, these complementing the on-the-spot training received by mothers while working as teachers' aides in the programme.

5. *EPIC (Education Programme for Infants and Children) at Preston Institute of Technology* (Clunies-Ross, 1976, 1977). This early intervention project for intellectually and emotionally handicapped preschool children and their families commenced in 1976. One of the major assumptions of the project is that since parents of handicapped children need emotional support as well as specific help in raising their children, the intervention should focus on parents as well as the child. To this end, one or two mothers are rostered to act as teacher aides and parents take part in a ten-week, three hours per week, course in child development and child management. Parents are taught general social learning principles and their specific applications to their own children. The weekly sessions are divided into a lecture-discussion and a small group discussion-laboratory. As part of the course, each parent is required to implement programmes at home with their children and to bring back to the weekly meetings records of the child's performance. Home programmes entail approximately half an hour of structured teaching per day. At the conclusion of the course parents are encouraged to develop further programmes at home, and group meetings of parents to discuss progress are held monthly.

6. *Parents as Language Therapists for Intellectually Handicapped Children, Australian Capital Territory* (Rees, 1976). This project commenced in 1975 with the aim of establishing a language intervention programme for moderately to severely intellectually handicapped children,

and in 1976 it evolved to a systematic evaluation of the effects on children's receptive and expressive language development of three intervention strategies. The first of these involve a behavioural approach in which parents are trained in operant learning principles; the second is based on a "developmental speech therapy model of language intervention"; the third group receives supportive counselling from trained social workers, with no systematic effort to involve parents in the training of their children. Parents in all three groups are involved in group meetings once a fortnight during the nine-month period of treatment and, in addition, the mothers involved in the first two groups bring their children to the weekly sessions of those intervention programmes.

7. *Monnington Parent Guidance Centre, Melbourne* (Hewitt, 1974). This Centre commenced in embryonic form in 1970 and has since developed into a multi-disciplinary service staffed by teachers and a variety of consultants (such as psychologists, speech therapists, and social workers). It caters for children from birth to 4½ years who have hearing impairment, visual impairment, language disorders, delayed development, or any combination of these conditions. The main aims of the centre are -

> Firstly, to increase the family adjustment to, and understanding of, the handicapped child.
> Secondly, to promote patterns of management which will elicit maximum responses from the child, while seeking practical parental participation.
> Thirdly, to make available to the parent, in a climate of ongoing support, information about the handicapping condition which will enable realistic adjustments to be made in terms of the child's future life.
>
> (Hewitt, 1974, p.4)

To these ends, a teacher and an appropriate consultant are assigned to each family. The consultant works closely with the teacher to develop relevant programmes and is responsible for the on-going evaluation of progress. The teacher's role is to demonstrate specific techniques for parents to carry out at home, the emphasis being on teaching parents how to teach their children. In addition, parents have access to a library from which they can borrow books, pamphlets, and cassettes on a range of topics, and a toy library is also available. Home visits, free taxi services within Melbourne, and free rail vouchers for country parents as well as low-cost overnight accommodation, all help to make this service accessible to a wide range of families.

8. *Home Training Section of Correspondence School, New Zealand Department of Education.* For some years the Home Training Section has been catering for handicapped children of school age living in any part of New Zealand who, for any reason, are unable to attend regular or special education facilities. The scheme was extended to preschool

handicapped children in 1977. In this programme, parents are provided with guidance and materials designed to meet the needs of their particular child. Although there are occasional home visits from the Wellington-based staff of the Home Training Section, the emphasis is on a two-way correspondence between the families and the teachers, supplemented by regular radio broadcasts.

9. *Dawnstart, Wellington, New Zealand* (Straton, 1975, 1977). This project began in Palmerston North in 1975 as a developmental clinic catering for children whose developmental age is between 0 - 30 months. Since 1977 it has also been operating in Wellington and is in the process of being extended to deal with older preschool children in the Wellington Metropolitan area (Early Birds Project). The main concern of Dawnstart is to arrange and monitor individually-based programmes for handicapped infants to be carried out in the homes, while Early Birds also has a concern for giving parents effective coping strategies but, in addition, involves a great deal more contact with other children and adults in group settings.

10. *PATH (Parents as Teachers of the Handicapped), University of Waikato, New Zealand.* This project will commence in 1978 under my direction and will have two inter-related themes. Theme One will have as its aim the development, evaluation, and dissemination of materials designed to help parents facilitate the development of their handicapped children. There is a considerable and growing body of literature and materials of relevance to this theme - some of which has already been mentioned above - but a good deal of it is inaccessible not only to parents, but also to professionals who work with families. In order to build up resources in this area, tape-slide programmes with accompanying booklets directed at parents of handicapped children and video-taped programmes suitable for use with professionals working with families of handicapped children will be developed. Theme Two will have as its objective the evaluation of the effects of two contrasting programmes using parents as teachers of their young intellectually handicapped children.

Conclusion

In this paper, I have stressed that special services for handicapped children are in danger of becoming institutionalised and divorced from the primary ecological system in which the handicapped child spends most of his time. In particular, I have argued for a re-evaluation of the educational importance of the family. I have recommended that the family be viewed as an integral part of the total system of care for the handicapped and that parents should be actively involved and accurately informed about their children's development right from the time of identification. And, finally, I have advocated

that the family system, rather than the individual isolated child, should be the prime focus of services. Taken together, these points have radical implications for the way in which the roles of professionals in health, education, and welfare are defined and for the ways in which they should be trained to fulfil these roles.

References

Berkowitz, B.P. and Graziano, A.M. Training parents as behavior therapists. *Behavior Research and Therapy*, 1972, 10, 297-319.

Bricker, D. and Bricker, W. *Infant, Toddler, and Preschool Research and Intervention Project Report - Year III*. Nashville, Tennesee: Institute on Mental Retardation and Intellectual Development, George Peabody College for Teachers, 1973.

Clunies-Ross, G.G. *EPIC. Annual Progress Report, Children's Centre*, Preston Institute of Technology, August 1977.

Clunies-Ross, G.G. A model for early intervention with developmentally handicapped preschoolers. The Children's Centre at Preston Institute of Technology. *Australian Journal of Mental Retardation*, 1976, 4, 23-27.

Cohen, S. and Gloeckler, L. Working with parents of handicapped children. A statewide approach. *Children Today*, 1976, 5, 10-13.

Cunningham, C.C. and Jeffree, D.M. The organization and structure of workshops for parents of mentally handicapped children. *Bulletin of the British Psychological Society*, 1975, 28, 405-411.

Futures of Children : Categories, Labels and their Consequences. Nashville, Tennesee: Centre for the Study of Families and Children, Vanderbilt University, 1975 (published by Jossey Bass, 1976).

Hayden, A.H. and Haring, N.G. Early intervention for high risk infants and young children : Programs for Down's syndrome children at the University of Washington in T. Tjossem (ed.) *Intervention Strategies for Risk Infants and Young Children*. Baltimore: University Park Press, 1974.

Hewitt, H. Designing programs to meet the total needs of the child and the family. Paper presented to Fifth International Conference for Deaf/Blind Children, Condover, Shrewsbury, U.K., 1974.

Jeffree, D., McConkey, R. and Hewson, S. *Annual Report of the Parent Involvement Project*, Hester Adrian Research Centre, 1975.

Johnson, C.A. and Katz, R.C. Using parents as change agents for their children: a review. *Journal of Child Psychology and Psychiatry*, 1973, 14, 181-200.

MacDonald, J.D., Blott, J.P., Gordon, K., Spiegel, B. and Hartmann, M. *An experimental parent-assisted program for preschool retarded children.* The Nisonger Center and Department of Communications, The Ohio State University, c.1974.

Nay, W.R. A systematic comparison of instructional techniques for parents. *Behavior Therapy*, 1975, 6, 14-21.

O'Dell, S. Training parents in behavior modification: a review. *Psychological Bulletin*, 1974, 81, 418-433.

Rees, R.J. Parents as language therapists for intellectually handicapped children. *Australian Journal of Early Childhood*, 1976, 1, 30-41.

Shearer, M.S. and Shearer, D.E. The Portage Project : A model for early childhood education. *Exceptional Children*, 1972, 39, 210-217.

Straton, E.A. Creating their own minds : A case for cognitive stimulation of handicapped infants, *Delta* 17, 1975 (published by Education Department, Massey University).

Straton, E.A. Improving rates of development in a group of handicapped infants - the Dawnstart Project. Invitational Conference on New Zealand Research in Child Development, Massey University, 1977. (Proceedings to be published by New Zealand Council for Educational Research).

Thorley, B., Pieterse, M., Cairns, S. and Redmond, A. A model for investigating the effect of early education of the intellectually handicapped. *Annual Progress Report of Down's Syndrome Project*, Macquarie University, December, 1976.

CHAPTER 2

Second Keynote Address

SIGNALS

Geoffrey Swan

One of the definitions for *SIGNALS* in the Concise Oxford Dictionary says:"*Preconcerted or intelligible signs conveying information or directions especially to persons at a distance*", and I trust that this is an appropriate title for this paper.

Let us look at the provision of special education historically, hoping that by doing this we will have an appropriate viewing distance. We cannot detach or divorce ourselves from our history. We can, and we do, try to forget unpleasant sections of our history, and it is always easier to see the interaction of people and events more accurately with hindsight than with foresight.

The earliest history of care and concern for the handicapped was one of misunderstanding and superstition, and Gearheart and Weishahn place this period from the beginning of man up until about 1800. There are numerous scriptural references to the deaf, the lame and the blind, and Christianity was responsible for considerable change in attitudes towards the less fortunate. Before Christian times, the Spartans, the Romans and the Athenians, imbued as they were with the purity of the race, found elimination the simplest answer to the problem. Some societies were not so brutal - there is a sculpture dating back to about 3000 B.C. and taken from the Temple of Memphis and now preserved in Copenhagen which shows a gatekeeper with what authorities now regard as a spastic condition. It is perhaps the earliest record we have of an integrated handicapped person!

Hebraic Law and late Christian teachings exhorted that the handicapped should be aided, and there are some instances of the practical implementation of this prior to 1800. St. Basil's Hospice for the Blind was established in the fourth century, and later Louis IX (Saint Louis) founded in 1260 a hospice for the soldiers blinded during the Crusades. Unfortunately, this hospice encouraged its inmates to augment funds by begging.

Another significant event in the sixteenth century was the success of Pedro Ponce de Leon, who successfully taught a small group of deaf children to speak, thus breaking the long-held belief and superstitition that deaf people were ineducable and incapable of benefiting from any kind of teaching. It would be foolish to suggest

that because Australia was not settled until 1788 that we missed out on this era; such is not true. We, or rather our forebears, brought their prejudices with them and when one thinks of the vicissitudes of the physically and intellectually able pioneers, the handicapped probably fared very poorly.

The changed concept of individual worth in the early part of the nineteenth century heralded the period described as the Age of Institutions, and that is where Queensland commenced its activity in the area of special education. We read in the Parliamentary Reports for 1889 a statement by the Inspector of Orphanages who said:

> *There were 13 children in the Deaf, Dumb and Blind Institute in Sydney at the end of the year: 1 was admitted and 4 discharged during 1888. These children cost £36 per annum each, £30 for maintenance, and £6 for clothing. The sum of £442.10.0 was sent out of the colony to support them; this money will be retained and spent here, as soon as the committee erect the necessary buildings at Woolloongabba.*

The committee he referred to got under way and in 1893 an area of land at what was then known as Woolloongabba, but is now known as Annerley, right away from the centre of population, was vested in a Board of Trustees. It is well to note that for neighbours the blind, deaf and dumb - as they were then called - had Dutton Park Cemetery, Boggo Road Jail, and the Diamantina Orphanage. The Institutional Era was also the Era of Complete Segregation. The handicapped were to be neither seen nor heard.

Queensland state school provision in this part of this century commenced with the establishment of the first opportunity classes attached to South Brisbane Boys' School in 1923. With W.F. Bevington, Inspector of Schools, as the guiding light, classes were established for both the mildly intellectually handicapped and the moderately intellectually handicapped. This was a remarkable provision for an Education Department. You will know that in most parts of the world the moderately and severely intellectually handicapped were regarded as ineducable, although some were described as trainable. It was thought that care for them was purely custodial, and many were placed in mental hospitals or asylums, as they were then termed. Little effort was made to teach these children. Unfortunately, the classes for the moderately intellectually handicapped - which were for boys only - were closed in the early thirties, schools could not manage appropriate programs, and the presence of the children in the school seemed to disturb some of the parents. Various suggestions were made about caring for these children. An island colony was one, but the Backward Persons Act of 1938 gave the responsibility to the Department of Home Affairs, and the Department of Public Instruction was no longer responsible for classes for moderately handicapped children.

The thirties, forties and fifties ushered in the era of parent and citizen involvement. We find the Queensland Society for Crippled Children commencing activity in 1932, and the establishment of a State School at Montrose Home two years later. The Queensland Society for Crippled Children was initially concerned about the children who had suffered from poliomyelitis, a condition now almost unknown in our community because of the successes of medical science.

It was in 1933 that the residential section of the School for the Deaf and the Blind was moved from the administrative control of the Department of Home Affairs to the Department of Public Instruction. The Parliamentary Report of this change described it as an improvement in many ways - for some years one department provided the teaching services and another the residential services.

The Queensland Spastic Welfare League was founded by a group of interested citizens and concerned parents in 1954. A treatment and training centre was set up in a magnificent old home in New Farm. The Queensland Department of Education provided teachers and later a school was built as part of the Spastic Centre complex. The need for this centre was demonstrated by the increasing number of cerebral palsied children surviving as a result of medical and scientific progress. A condition that once caused infant mortality and was purely a scientific and medical problem, became a complex educational and social problem when the children survived.

Another monumental effort on the part of parents to ensure education for their handicapped children, was the establishment of the Queensland Sub-Normal Children's Welfare Association. At this time, these children, because of their condition, were excluded from state schools and the responsibility for the establishment of day care centres was that of the Department of Home Affairs (now the Department of Health) which later, and still, provided subsidies for this organization.

Other organizations, the Autistic Children's Association and the Queensland Association for the Pre-School Education of the Deaf, were parent motivated, and commenced to provide services.

A more recent organization, SPELD, commenced activity as a parent support organization. It aims at assisting children with learning disabilities, but tries to do this through the existing structures.

The Down's Syndrome Association and the Queensland Spina Bifida Association are both parent motivated groups with support services for parents and the client group.

New professions have emerged in this century and with the professions an appropriate body of knowledge. The psychologist, physiotherapist, the speech therapist, the occupational therapist and

the social worker all have an important part to play in the care and habilitation of the handicapped. There were problems in establishing independence of each discipline, and certainly role conflict inhibited the movement of these new disciplines into the schools which were once the exclusive working place of teachers. These people brought entirely new dimensions to the work as they form part of the team.

The training of teachers specifically for work in special education has been another development of this century. Departments of Special Education are now a feature of many Colleges of Advanced Education and Universities, and Queensland must consider itself very fortunate indeed for having had Fred and Eleanor Schonell working here. Their impact and influence on work with all children was considerable. Sir Fred Schonell took up the Chair of Education at the University of Queensland in 1952.

Handicapped people and their aspirations have also influenced our attitudes. The spate of autobiographies that were either published or republished in the last thirty years indicates that handicapped people do have a positive contribution to make, and I think particularly of Carlson's work *Born That Way*. When Little, in 1892, gave his clinical description of spastic paralysis, feeblemindedness was regarded as an integral part of cerebral palsy for quite a few years.

How real and unreal have been expectations for the handicapped?

Research has now become an integral part of the special education activity, and one hopes that the supply and delivery of services to the handicapped are flexible enough to adjust and adapt to the results of reputable research.

Learning disabilities is an area that has received a considerable amount of attention in the last twenty years. It has, as most educators claim, grown rapidly and continues to experience phenomenal growth. Some of the "discoveries" in the area tend to be distorted and it has taken some time to view these in perspective. Successful research in one area of exceptionality can have considerable effect in another. For example, medical research into the prevention of poliomyelitis, the reduced infant mortality rate, the aggressive surgery on children born with spina bifida, the development of hearing aids, the effective treatment of trachoma, the use of anti-convulsant drugs are just some of the instances that have changed dramatically the nature of special education.

No parent would want to have a handicapped child by choice. Very little seems to be written about the parental role, and some of our material seems to be based on the observation of a few parents. Roith (1974) in writing about this very topic, says that the frequent occurrence of words such as guilt, shame, hostility and remorse gives one a completely biased and prejudiced impression that immediately sets the worker on the defensive.

The parental role is that terribly important one of *being a parent*, not a teacher's aide, nor a therapist's aide, but a parent with a unique relationship with a child.

The Signals

1. *Superstitions and misunderstanding*

How much more understanding and less superstitious are we today? Has public education been sufficient and realistic enough to allay primitive superstition and improve understanding of the handicapped?

2. *Begging for the handicapped*

Have we become more subtle than the people in the Hospice of Louis IX? How much of the work with the handicapped still depends a great deal on the proceeds of raffles, bingo and contests? Are we equating social responsibility with a begging bowl? What effect does this have on the people we are wanting to assist?

3. *Costs*

Are we still evaluating programs in terms of cost? Are we still like the Inspector of Orphanages in 1889? Certainly one should expect value for money. The outcomes for individuals should be the prime consideration.

4. *Education for all children*

When Bevington helped establish his classes in 1923, he had in mind all children. Unfortunately, techniques were inappropriate for the moderately and severely handicapped and these classes disappeared. It is hoped terms such as "ineducable" have now disappeared.

5. *Institutions for children*

The medical model for the care of handicapped children has been found wanting. Placing handicapped children who are not sick in hospital-like establishments must be the most inappropriate placement possible. Handicapped children are not necessarily ill children, although they may need some form of medical care.

6. *Parent organizations and the provision of services*

Do parents still have to raise funds to provide services for their children? The forties seemed to be the era in which this had to be done. Parents have an important role to play in being effective parents. They should not have to be fund-raisers, physiotherapists, occupational therapists, or speech teachers or teacher aides.

7. *Teachers are now better trained than ever before*

Programs are, and should be, much more effective as a result of this.

8. *Aspirations and expectations of the handicapped*

These have been unrealistic - sometimes too low, leading to frustration and sometimes too high, bringing disappointment.

9. *Research*

Research has helped us to a better understanding of the handicapped and much of this has had a great effect on the understanding of non-handicapped children. Research in different disciplines needs to be disseminated in language that can be understood.

10. *Constantly changing patterns of needs and provision* leave no room for complacency.

References

Carlson, E. *Born that way.* Evesham : Arthur James, 1952.

Gearheart, B.R. and Weishahn. *The Handicapped Child in the Regular Classroom.* Saint Louis : C.V. Mosby Company, 1976.

Gearheart, B.R. *Administration of Special Education.* Illinois : Charles C. Thomas, 1967.

Kirk, S.A. *Educating Exceptional Children.* Boston : Houghton Mifflin Company, 1962.

Miscellaneous Papers - Queensland Government Archives.

Queensland Parliamentary Papers (1875 - 1977). Brisbane, Government Printer.

Roith, A.I. *The Myth of Parental Attitudes*, In Boswell, D.M. and Wingrove, J.M. (Eds.), *The Handicapped Person in the Community.* London : The Open University, 1974.

Younghusband, E. *Living with Handicap.* London : National Children's Bureau, 1970.

CHAPTER 3

COLLABORATION BETWEEN MEDICINE, EDUCATION AND WELFARE IN THE INTERESTS OF CHILDREN : A MEDICAL VIEWPOINT

H.M. Connell

Perspective

In mediaeval times the concept of childhood as it is known today did not exist. Children were either infants or, as soon as they could leave the constant attention of mother or nurse, miniature adults. This is reflected in paintings of the period where children are given adult proportions. Those of noble birth, destined to fill important roles were trained carefully but the lot of most children was to assume responsibilities as early as possible. Infants were of little concern as their hold on life was tenuous: children were treated as servants and chattels and child marriages, arranged to suit the convenience of families, were not uncommon. This did not signify cruelty on the part of parents - most showed great affection toward their offspring. It was an attitude of mind derived from the fact that childhood, as a period of special needs, had literally not been discovered. It reflected too, the very short life expectancy of adults of the times. To reach thirty was to be old.

With the coming of the industrial revolution, children were exploited as a cheap source of labour. Boys and girls had to get every possible penny into their impoverished, and overcrowded homes. The condition of chimney sweeps was perhaps the most piteous. The job involved climbing up long, twisting, soot-covered flues. Chimneys were not always cooled adequately before the lad went up, nor was it unknown for a master to light a fire underneath to hasten the progress of a reluctant boy. Elbows and knees had to be toughened to aid climbing. One Nottingham sweep is on record as saying, "no one knows what cruelty a boy has to undergo in learning. The flesh must be hardened. This is done by rubbing elbows and knees with the strongest brine close by a hot fire. You must stand over them with a cane or coax them with the promise of a halfpenny." (Reader, 1973). Even when the skin was raw, it had to be rubbed with brine again and again.

Children working for parents were no less exploited. One girl told of her five and a half year old sister, who had already worked for two years stitching gloves. She was pinned upright to her mother's knee and slapped upon the head to keep her awake on Thursday and Friday nights when late orders had to be completed (Reader, 1973). The Earl of Shaftesbury's crusade for improved working hours resulted in an "enlightened" law of 1833, which was passed over savage opposition. Children between nine and thirteen were not allowed to work more than a forty-eight hour week. Those between thirteen and eighteen not more

than sixty-eight hours; but this law did not apply to children working down the mines, many of whom were crippled by lack of sunlight and desperately hard work.

It was quite common for parents to leave infants drugged with opium or gin when they left home for long hours to earn a pittance. Cirrhosis of the liver due to chronic alcohol ingestion was not unknown as a cause of infant deaths in the eighteenth century. By our standards, childhood mortality was inordinately high. A child born in eighteenth century London had only a 50-50 chance of surviving beyond his 5th birthday. In the industrial north of England, Aspin (1969) reports that 62% of the population died before the age of 5.

Of course some children were carefully nurtured, but harshness invaded much of the childhood of the Victorian age. The headmaster of a famous British school got his lists mixed up, and in error, "soundly thrashed" a group of boys who presented themselves for church. He was not unduly concerned however, as physical punishment was a regular occurrence and it was common to ask a schoolboy, "when were you last beaten?" (Reader, 1973).

Social conditions for children in the first settlement at Sydney Cove in 1788 were little better, although there is some evidence that the "boundious" sunshine" of the Antipodes compensated to a degree (rickets was unknown), but food was limited and the diet unsuitable. A disproportionate number of the child population were born to unmarried convict women and the quality of care they received was questionable, to say the least. Problem families appear to have been recognised by the administration and attempts made to help their children even at this stage. In 1789, a four year old girl was removed from the care of her mother (described as an abandoned woman), in order to save her from "inevitable ruin", and sent to Norfolk Island to be taught reading, writing and husbandry (Gandevia and Gandevia, 1975).

In the face of so many physical problems, it is hardly surprising that, generally, the child's psychological development received little attention. Later however, sporadic observations were made on deviant childhood behaviour in the 18th and 19th centuries. The difference between mental subnormality and mental illness in children was recognised and there was a growing awareness of individual differences and the need to cater for them. The first description of an autistic child was made by Haslam in 1799 (Walk, 1964). A boy of ten years was studied at the Bethlem Hospital in London. He suffered a change in character at two, became the unrelecting foe of all glass, china and crockery, incapable of forming relationships and inaccessible to any display of kindness.

Management of these disturbed children was often harsh, since they were held morally responsible for their behaviour. In 1850, Crichton-Browne recommended a humane approach; a wholesome diet, cod liver oil and general cleanliness were to replace the lash and solitary confinement.

Controversy about the nature of psychiatric disturbance in childhood was considerable. Kraft-Ebing and Heller postulated an organic basis, such as physical or brain deterioration. Later, when higher education for women raised fears that female intellects might be overtaxed with knowledge, scholastic overstrain gained support as a cause of mental breakdown.

During the first years of the 20th century with the conquest of many of the physical ills of childhood, horizons widened and included psychological and social aspects of child development. Advances in bacteriology made the prevention of infectious diseases possible. Could psychological disturbances be similarly prevented? It was with this in mind that Juvenile Courts and later Child Guidance Clinics were instituted. Because of the complexity of many of the family problems encountered, a team of psychiatrist, psychologist, teacher and social worker evolved to tackle them.

Routine medical examination of school children started at the turn of the century and represented the first integrated effort of medicine and education to work together for the welfare of children. Compulsory education, introduced in the 1870's in Queensland, not only drew attention to children unable to benefit by standard teaching, but placed all children in a situation where abnormalities could be detected and measures taken to improve their health.

In the detection of handicaps, particularly sensory defects and orthopaedic conditions, routine inspections were of tremendous value and the School Medical Service has a praiseworthy record in this respect, especially since the geography of Queensland makes for particular difficulties. Since social conditions often contribute to the child's total handicap, integration with child welfare services was the next logical step. The development of the Division of Youth Welfare and Guidance offered facilities for referral and treatment of children with psychological problems. An important new development has been the appointment of school counsellors by the Education Department. These people have time and ability to advise on matters relating to the total well being of the child.

Working together - the 'whole child' approach

At this point, it is appropriate to consider clinical situations in which medical, educational and social agencies must work together to serve the interests of the child. This is not a complete list but it represents important areas where integration is essential. These situations are seen through the eyes of a clinician and from a medical viewpoint, but that is commensurate with the title of this paper.

(i) *Schooling in hospital and the prevention of invalidism.*

For whatever reason a child misses school, absences represent social handicap. Not only does he fall behind with his school work, but he misses social interaction with peers and the discipline involved in learning.

The philosophy must be that the classroom is the natural place for a child during school hours and unless there is very good reason for absence, he should be in it. A hospital school offers the means of ensuring that the child with prolonged illness continues his education and, as is often the case, makes up for time lost before admission. If he is physically incapable of coming to school, teachers may visit him in the ward.

Sarah, an 8 year old, suffered from burns involving 70% of her body surface. After 4 weeks in hospital she was referred for a psychiatric opinion because of her severely depressed state. She was withdrawn and apathetic. In fact her main social responses were anxiety and infantile whining whenever dressings had to be changed. Management involved paramedical, nursing and medical staff working together to improve her reaction to her physical state. A most important member of this team was the teacher. Sarah's arms were immobilized by scar tissue and work had to be done by word of mouth; nevertheless school work represented a return to normal life and a step toward rehabilitation. Sarah's scars are such that her work prospects are limited and her educational level will be an important factor in deciding her eventual employment. In common with many children who suffer accidents, Sarah came from a background of social problems. Social worker involvement with the child's family makes the return home easier for these tragic children.

Chronic physical illness always has psychological overtones and there is no doubt whatsoever that an attitude of invalidism produces psychological crippling which can be a more severe handicap than the primary one. School attendance during hospitalization is an effective antidote to this. No matter how well a ward is run it has overtones of sickness. School as a normalising influence and teachers' attitudes help the child adapt to his handicap. The Education Department's laudable efforts to integrate handicapped pupils into the general school system whenever possible, means that teachers are involved with crippled children more than previously. Their management of these children has important implications for the medical profession.

The establishment of a Psychiatric Unit in the Children's Hospital has meant that patients with emotional and behavioural difficulties can be admitted. In most of these, education has suffered in one way or another and schooling in hospital represents a most important aspect of treatment both from remedial and disciplinary aspects. At this point, I should like to express my warmest admiration for Miss Heather McDonald and her staff, who coped over the years in the most difficult conditions - as anyone who has seen the old school will know - and made school a rewarding experience for thousands of children during their stay in hospital.

(ii) *School refusal - the neurotic child.*

The truant has long been with us, but there is evidence that school phobia, where the child has an irrational fear of school is becoming more common. Typically, this disorder presents at two periods of school life. In the early grades, when it represents anxiety resultant to the separation of a mother and her over-dependant child, and at puberty and the start of high school. In the latter group, there are indications of more serious disturbance, commonly early personality disorder and neuroticism. The clinical picture is of an anxiety ridden student who is the product of a neurotic family. Most of these patients are potentially good students and loss of schooling has serious implications. Because they frequently show an admixture of somatic symptoms - and manipulative (and their mothers are nothing, if not manipulative), it is common for them to have missed an inordinate amount of schooling before they reach medical attention. Some refusal requires urgent treatment. Aside from anxiety about catching up, the more the child is absent, the more he misses the normalising influence of peers and the closer he is thrown into interaction with his neurotically disturbed family.

Many school refusers come to attention so late that a return to school is extremely difficult, sometimes impossible. There is probably no condition where it is more important for doctor, teacher and social worker to collaborate in management. Picking the child whose reasons for absences seem invalid, and whose over-anxious mother pushes him to school physically, but by her demeanour and tone of voice subtly encourages him to return home, may not be too difficult, but getting parents to see the need for help is quite another matter. Immediate return to the classroom is essential and a teacher who is prepared to meet the child at the gate, make school as rewarding as possible and help him catch up, can often be a deciding factor in the outcome. The social worker has an equally important role. Someone prepared to escort the child to school if necessary, and to work with the family in order to improve their attitudes, can be invaluable. There is much to be said for making the curriculum more appealing to the 14 and 15 year olds, as well.

(iii) *The total management of the child with a learning disability.*

Nowadays there is no need to stress the problems of the child with multiple minimal handicaps. Long term studies such as those of Menkes (Menkes et al. 1967) and Anderson (Anderson, 1972) show a disquieteningly large proportion of these children grow into socially maladjusted adults and a few become psychotic. As Anderson says 'society pays the high cost of minimal brain dysfunction' (Anderson, 1972). The initial presentation of these children may be: to teachers because of classroom difficulties; to psychiatrists because of

emotional or behavioural problems; to social workers as society drop outs and delinquents. One example is a child who, at 8 years old presented with untidy work at school, and at 13 years as a psychiatric patient after attempted suicide.

Once a diagnosis of minimal brain dysfunction is made, it is imperative that all involved with the child know what his handicaps are through free interchange of information between professionals. Tailoring the child's education to meet his needs is a laudable aim, but can only be done if an adequate profile of his disabilities is obtained. If, as is sometimes the case, a child's activity level impairs his performance and drugs are prescribed, his teacher has a right to know what is happening. Her report on the effect of medication is likely to be more objective than that of his emotionally involved parents; and rating scales, such as that developed by Conners (Conners, 1969), give her the means of making a scientific approach.

Improved obstetric care has resulted in a larger number of children surviving the hazards of birth and among these, less severe neurological handicaps are seen than in the past. In fact, subtle impairments may not become evident until the child is challenged with school work. "At risk" registers for children likely to be affected, have been tried but have proved a mixed blessing leading parents and teachers to anticipate trouble unnecessarily. It is important to remember that normal variation in childhood can be very wide.

(iv) *The disadvantaged child.*

Children may be disadvantaged because of poor socio-economic backgrounds or unstable family relationships, or both. When, as happens today, one marriage in four ends in divorce before the children of the union reach school leaving age (Brit. Med. J. 1972), it is axiomatic that large numbers of youngsters are at risk of developing emotional disturbance resultant to their parents' marital problems.

The Family Law Act of 1974, makes the best interests of the child a primary concern when custody and access by parents, is being determined. Although members of the Family Law Court make every effort to implement this, matters can go astray and children may become torn between two warring parents, each determined to have his or her way. Social workers are primarily involved with these cases but some reach medical attention, often because of behavioural symptoms. Schools may have a very important influence on these children, offering stability in a world of dissent and changing values. If the teacher is informed about what is happening in the child's life, then her sympathy and understanding can do much to mitigate the effects of violence in the home. In one parent families, the teacher's potential as a substitute identificatory figure is very great. In fact, recognition of this has led to the introduction of male teachers into the early grades of school and into kindergartens.

For the culturally disadvantaged child, school can be a discouraging experience. Poor physical care, lack of fine motor and language skills, negative attitudes toward staff and lack of motivation, all combine to produce a child who is likely to become a school failure. Programs such as Operation Headstart have shown that an early enriched environment can help these children in the early grades. Unfortunately, performance tends to fall off during school life, since the home is unable to support and sustain the child's progress. It is suggested that social worker involvement with the family may improve this by altering parent attitudes to the value of education.

(v) *Topical problems.*

Pregnancies in younger teenage girls have been increasing steadily in numbers over the past few years (Brit. Med. J. 1975). The reasons for this are unclear but feelings of deprivation and rebellion in the girls seem to be important. Less intelligent girls are at greater risk. The hazards for children born of such pregnancies are considerable and include increased perinatal complications, physical illness, cruelty and neglect. For the girl herself, and here I quote from a memorandum prepared by the Royal College of Psychiatrists in England (Roy. Coll. Psychiat. 1977) 'there is inevitably serious disruption of schooling together with exposure either to the mental and physical complications of termination or to the responsibility of making decisions about adoption or caring for the child before she is sufficiently emotionally mature'. Can teachers, doctors and social workers combat this problem and the associated one of the increased prevalence of venereal disease in young adolescents?

I believe they can in the following ways:

1. Sex education in schools needs careful appraisal and a realistic approach. It should be entrusted to mature, well informed individuals and not the youngest member of the biology staff. It must be treated within the context of a discussion of inter-personal relationships generally, and not as an isolated phenomenon. Sessions in which members of all three disciplines listed above, give advice to students would be ideal.

2. Health education for boys and girls should include practical details regarding contraceptive methods and means of obtaining contraceptive advice. From the point of view of prevention, it is the imparting of practical knowledge that is important, since this is very often not provided by the family. Moreover this must be geared to the less intelligent. Facts relating to venereal disease must also be clearly defined.

3. In health education, the importance of early reporting of pregnancy should be stressed, and quoting from the memorandum mentioned above 'In every secondary school there should be some identified person to whom a girl can go for a discussion

in confidence if she thinks she may be pregnant', end of quote. This person should have a thorough knowledge of all methods of helping the girl.

Should the girl keep her pregnancy, it is most important that her schooling be continued up to the confinement. In the U.K. special classes are arranged for pregnant school girls. These include mothercraft and child development. Correspondence courses could be arranged here. There is no doubt that adoption is in the best interests of the baby, and if this is arranged, rehabilitation and return to school as soon as possible are essential, if the mother is to take her place in society subsequently, and indeed, these may act as deterrents to re-conception.

Figures relating to the misuse of drugs and alcohol by Queensland school children were published in 1975 and although the survey was open to methodological criticism, it produced an alarming picture. Recognition of the child at risk for drug dependency because of personality or family difficulties and a knowledge of the symptoms of drug abuse is essential for all those involved with young people. Teachers need help in this respect, both by giving information (drug fashions change rapidly) and by having agencies to which they can refer when necessary. As in the case of school refusal, many of these youngsters reach help at too late a stage. Education relating to the dangers of drug experimentation and misuse is an important deterrent. In Queensland, the Juvenile Aid Bureau could well be involved with schools in this respect.

(vi) *Early detection of psychiatric disturbance.*

What has been said about drug abuse is relevant to this. Early detection of serious emotional disturbance is essential to satisfactory treatment, particularly so in the case of schizophrenia. The gifted student who fails to fulfil his promise, who becomes apathetic and withdrawn, with bizarre interests and behaviour - is his problem more than a particularly disturbed adolescence? Again, the teacher is in the best position to pick the early signs. A study of juvenile suicides in Brisbane (Connell, 1972) showed nearly every one had communicated their ideas of self-destruction to adults, often teachers, before the event. However, if teachers are to act effectively in the interests of these youngsters, they must have adequate liaison with, and the backing of, psychiatric and social services.

So often there is an administrative block between the teacher becoming aware of a disturbed pupil and obtaining help for him. Physical conditions in which children are reared have improved immensely in the past century, but now children are subject to more subtle pressures, not the least of which is high pressure advertising and the ubiquitous television set. A recent inquiry into children's television, shows that

public conscience is awakening to the problems imposed by mass media upon young people. It is up to those concerned with the development of children to keep such matters within the public eye.

Automobile accidents, which commonly involve head injury, have increased in prevalence over the past 3 decades. Rehabilitation of the brain damaged child, his education and choice of a career is a most important area for integration of the disciplines under discussion. These children have all their life ahead of them. Cognitive deficits often improve surprisingly - the young brain has tremendous reserves - but the behavioural difficulties which may be so severe as to impair the child's total functioning, require the attention of doctor, teacher and social worker combined.

Looking into the future

It has been implicit in all that I have said that efficient communication between disciplines involved with the welfare of the child is essential in order to further his interests. Teachers, medical staff and social workers use their own jargon, incomprehensible to others and often, like charity, it covers a multitude of ignorances and omissions. If these professions are to communicate effectively, then they must have the basic tools with which to do so. Probably this should relate to training at the student level, to interdisciplinary teaching in training colleges, medical schools and social work departments. One has no desire to produce jacks of all trades; but there is a very great need for all to have sufficient knowledge to make communication between the specialities effective. It follows that once a common language has been achieved, then facilities for liaison between the disciplines must be improved. The falling birth rate makes for smaller classes and allows more time to study individual differences among pupils. If these are to be appreciated and allowed for, doctors, school nurses, teachers and social workers must have an opportunity to meet and exchange information.

It has been a practice in the Children's Hospital for several years to hold a weekly meeting of a team comprising the headmistress of the school, a guidance officer from the Department of Education, a psychiatrist, a psychologist, nursing staff, a social worker, a speech therapist and a play therapist. In addition others involved with a given child's welfare may be invited. This allows detailed discussion of child patients and often their families, and realistic planning for their management and future. It is true that this is done under ideal conditions but it should be possible to extrapolate to other schools. The benefits of interpersonal discussion are obvious. The time saved by not having to write reports outweighs the disadvantages of some personnel having to travel to the school. A constant problem faced by professionals who work with children, is the family who 'shops around'.

It is not uncommon in Psychiatric Outpatients to be faced with a child who has been seen at one or two hospitals (often by several specialists), the school medical officer, the Children's Services,

the Department of Guidance and Special Education and the Division of Youth, Welfare and Guidance. Parents may obfuscate because they want an unbiased second or even third opinion, but many are confused and forgetful and have no intent to withhold information. Work with children can be duplicated, triplicated or more because of this. One way of reducing this problem would be to establish a central record system of children with chronic handicaps to which various agencies could refer for information when a child was brought to attention. The establishment of a centre for developmental assessment in the early years of life, within the Children's Hospital would offer an excellent start for a scheme such as this.

Finally, comes the subject of research. Schooldays are the only period of the human life span when the whole population is captive and, although this lends itself particularly to research, it is probably not utilized as effectively as it could be. There are many areas to be studied - the prevalence of learning disorders, methods of rehabilitating the brain damaged and the delinquent and the integration of children from differing ethnic and minority groups into schools are some of them. One of the greatest problems, and one which represents an enormous expenditure of public money, is the number of 'drop-outs' from high school and tertiary education systems. Most of these failures do not relate primarily to lack of intelligence or specific learning handicaps; these have been weeded out in the early grades. They relate primarily to *motivational* difficulties about which we know very little. The emotional factors which determine a child's adjustment to school and learning are tricky and intangible, but terribly important. This would seem a fruitful area to explore. The medical and teaching professions and sociologists have unique skills to contribute to this important area and by getting together and pooling information, could come up with very useful results.

In conclusion -

History gives no grounds for complacency about our management of children. The social, family and disease pressures on children today may be different from those of yesterday, but are certainly no less troublesome for the child.

For many children with chaotic backgrounds, school can be a most stabilising influence, somewhere which gives opportunities for creative activity, for interaction with peers and identification with mature and sensible adult figures. As such, this hospital school must be regarded as a sound investment for the future, especially so because of its unique position. It offers medical, educational and social work personnel an opportunity to work together and to study ways and means of furthering the interests of the most important of creatures - the child.

References

Anderson, C.M. *Society Pays the High Costs of M.B.D. in America.* New York, Walker & Co., 1972.

Aries, P. *Centuries of Childhood.* Ringwood, Vic. Penguin Books Australasia Ltd., 1960.

Aspin, C. *Lancashire. The First Industrial Society.* Preston, England. United Printing Services, 1969.

Brit. Med. J. *Editorial.* The plight of one parent families. 1972, 2: 667-668.

Brit. Med. J. *Editorial.* Pregnancy in adolescence, 1975. 3: 665.

Connell, H.M. Attempted suicide in school children. *Med. Jnl. Aust.* 1972, 1: 686-690.

Connors, C.K. A teacher rating scale for use in drug studies with children. *Am. J. Psychiatry.* 1969, 126: 884.

Gandevia, B., and Gandevia, S. Childhood Mortality, its Social background in the first settlement at Sydney Cove 1788-1792. *Aust. Paed. J.* 1975, 11: 9-19.

Menkes, M.M., Rowe, J.S., and Menkes, J.H. A 25 year follow-up study on the hyperkinetic child with minimal brain dysfunction. *Paediatrics.* 1967, 39: 393-399.

Reader, W.J. *Victorian England.* London. B.T. Batsford Ltd., 1973.

Royal College of Psychiatrists. *News and Notes.* Memorandum on Pregnant Schoolgirls and Schoolgirl Mothers (not available for general distribution). 1977.

Walk, A. The prehistory of child psychiatry. *Brit. J. Psychiatry,* 1975, 110: 754.

CHAPTER 4

COLLABORATION BETWEEN EDUCATION, HEALTH AND WELFARE: AN EDUCATIONAL VIEWPOINT

James Ward

Introduction

In presenting this paper I wish to pay tribute to the enterprise of the organisers in assembling a large and diverse interdisciplinary group of contributors, truly representative of the theme for the seminar. Its presence is a reflection of the growing attention given to the interdisciplinary approach in the technical literature, e.g., Andrews (1975); the existence of efficient interdepartmental delivery systems at both State and Commonwealth levels, e.g. the Commonwealth Rehabilitation Service and active organisations such as ACROD and AGSOMD which have a multidisciplinary composition. The necessity for a fully collaborative approach to the education and care of the handicapped is well recognized and, in the U.S. at least, is given a firm legislative basis through the public laws relating to developmental disability, Public Law, PL 91-517. Even so, most of us are agreed that it is essential that the concept be given continued advocacy in the strongest possible terms in view of its implications for the organisation of services for those at various forms of educational, medical and social risk. I wish therefore to discuss these implications under the following six headings which refer to important general areas of potential collaboration:

(a) statements of ideology and the identification of community needs;

(b) resource management;

(c) delivery systems and what they deliver;

(d) evaluation;

(e) creation of new approaches;

(f) research needs.

In this I will refer to three main problem areas for intervention in: education and care; the developmentally disabled; the field of learning disabilities, however defined, and the treatment of maladjustment or emotional disturbance. In some sense therefore the topics are habilitation, rehabilitation

and treatment. My comments will derive from two sets of general assumptions about the contemporary approach to problems in special education and about the nature of programmatic work.

The first set concerns a developing community's attitude to the handicapped that they should be educated and cared for in as normal an environment as possible: Wolfensberger's so-called normalization principle (1969). Allied to this are such concepts as *mainstreaming* Kaufman (1975) which allows for the spatial, temporal and curricular integration of children and deinstitutionalization with its consequences of community responsibility for care. Normalization implies not only massive changes in the social philosophy but reorganisation of services at all levels. Thus, delivery systems have to change their aims and their functions: in education this will require modification of training at all levels. Relationship to other systems must necessarily be changed and the evolution of new systems may be confidently anticipated.

The second set of assumptions refer to the technical nature of effective programming for the handicapped and would list aspects such as prevention, early identification, early intervention, continual positive discrimination in use of resources and long-term planning, monitoring of needs. Such approaches are common to all forms of service delivery and to their contributory disciplines. Most of the technologies to which reference will be made are derived from psychological and educational intervention; but these are now used by a very great variety of professionals and paraprofessionals and there is certainly no exclusivity attending to their use and future development.

(a) Ideology

A most important long-term focus for interdisciplinary cooperation is that of setting up corporate goals for the community's services for the handicapped. For some years now the themes have been deinstitutionalization and normalization and there is now evidence that consensus on these is gradually evolving. Progress, however, is slow and the most tangible evidence of an accepted ideology is that of fundamental legislation and the accompanying public acts which enable appropriate financial support to be given. The experience of the U.S. in the area of developmental disabilities is most instructive. Developmental disability is now the target for quite explicit interdisciplinary effort, authorized in public acts and reflected in the support given to research institutions, technical assistance programmes and all forms of service delivery. This represents an extremely interesting form of modern change agency, but much remains to be done and workers such as Keogh (1975) and Gallagher (1972) reiterate the need for continuing advocacy. The development of compassionate and supportive attitudes has to be accompanied by greater assumption of personal responsibility and all delivery systems tend to be involved in ongoing public education, particularly with a view to prevention.

(b) Resource management

If achieved, corporate goals must be translated into specific goals which can form the basis for policy and which can be incorporated into planning. It is here that professional input is most significant for if waste and duplication of effort is to be avoided there has to be interdisciplinary consensus over the identification of groups in need and the optimal use of resources to meet their needs. Here past experience has not been happy, particularly in the case of the severely and profoundly retarded and the emotionally disturbed.

Need is therefore assessed against a context of corporate goals and planning of the use and development of resource curves. It is evident that the magnitude of the problems involves resource management on a very large scale. For example, the combined 1976 budgets of the U.S. Departments of Health, Education and Welfare amounted to 179 billion U.S. dollars. To this figure must be added the cost of other community agencies which deliver direct services and which have been traditionally involved in major contributions to the education and care of children at risk.

Therefore the achievement of optimal use of resources is a complex and ever changing goal which all agencies must jointly pursue. The full mobilization and utilization of community resources can only evolve over time as planning, programme design and technology becomes more effective. As has already been stated it will also be brought about by successful change agency in terms of altering community attitudes. Among other things such positive change will be facilitated by exemplary forms of management. Here one thinks of management by objectives (MBO) and the application of the so-called matrix principle to resource management. The matrix system can readily accommodate the traditional statutory base to management by calling upon the relevant talents from other agencies in a problem orientated teamwork approach.

(c) Delivery Systems

However, irrespective of any informal and temporary arrangements which are made to capitalize upon resources, contemporary planning inevitably incorporates some formal concept of service delivery. We are indebted to military organisation, business management theory, and the experience of medical services for the main conceptual advances in a developing field. Service delivery requires explication of a target population; assessment of needs; a plan for the deployment of resources with a view to service delivery and evaluation.

The identification of target populations has of course a profound effect upon the development of the rest of the system and in the area of special education has long been a source of controversy. It is clear, to educationists at least, that such identification has been dominated by medical categorization systems rather than instructional needs. Although a rigid categorical approach to service delivery is now being relinquished in favour of much looser categories of handicap, compare Mittler (1976) it nevertheless tends to persist as a vehicle for funding.

The above issue continues to dominate the planning of provisions. A fundamental debate has proceeded as to whether there should be a single system for all children, irrespective of handicap; a system with sub-systems for special education or a dualistic approach with separate normal and special systems. Historically speaking the influence of medical and social welfare departments has tended to promote separatism: particularly in the case of medical control of facilities for the severely retarded or multihandicapped and emotionally disturbed and social welfare's involvement in correctional education. Both legislation and practice have tended to remove the more deleterious effects of this segregation. Even so it would be misleading to suggest that educationalists are unanimous in condemning highly specialized facilities, and some would consider that provision should be judged by its ability to deliver the appropriate technology favouring the special school or segregated approach, e.g., Throne (1973); Cruickshank (1974) at least for the severely handicapped or emotionally disturbed child.

What is delivered

Since it could be argued that the growth of technology will eventually determine the suitability or otherwise of various types of structure it is legitimate to enquire as to what is actually delivered to the client. In special education this might be summarized as the techniques by which he or she can learn acceptable levels of basic educational and self help skills; interact positively with others in the environment and thereby develop normal feelings of self worth. For these purposes the most sophisticated approaches are derived from psychological work into child development, learning theory and the social psychology of interpersonal relationships. Most of these, however, represent variations upon the general behaviour modification paradigm which seeks to gain control over the stimulus, environmental and contingent events in learning. In this the influence of Skinner (1953, 1968) has been dominant. Reviewing a large number of studies in the field Ward (1975) identified four basic aspects of methodology, operant and respondent conditioning; modelling and self regulation which form the basis for programmes.

In the search for an optimalized learning experience for all children several related technologies have been proposed. These give different emphasis to the behavioural paradigm according to the broad needs of their problem area. Thus, in the broad field of learning problems a technology of *direct instruction*, i.e., "if you want a child to know anything you must teach him" has been deployed with conspicuous success by social behaviourists as Becker and his co-workers (compare the Follow Through Planned Variation Experiment, 1977), using the "DISTAR" series of materials. The evidence here is based upon large samples of urban disadvantaged children and is cumulative, with little sign, thus far, of the 'wash-out" effect common to interventionist programmes. Similarly, precision teaching models now variously names: data-based instruction; exceptional teaching; adaptive teaching, etc., incorporate the same fundamental principles but with a greater emphasis upon monitoring and responding to the students' responses. Such technical approaches have the considerable advantage that they are replicable in the sense that effects of various salient factors can be identified and controlled in parallel settings. They can moreover be readily taught (compare White and Haring, 1976).

The more challenging areas of habilitation require an intensive and rigorous application of psychological principles involving a fine grained analysis of behaviour and very exact control over learning. The main problem encountered here is one of lack of generalization of behaviour but this is amenable to technical attack (see Stokes & Baer, 1977), and there is evidence that developmentally disabled children can now achieve basic skills in literacy, numeracy, self-help and communication at levels previously unknown. In the areas of emotional disturbance and social deviance the technologies are broadened so as to extend the therapeutic effects of the educational process. The various forms of behaviour therapy and counselling techniques are more complex in the sense that many are derived from the clinical practice of behaviour modification but are nevertheless available both for behavioural control and reprogramming towards adaptive and socially acceptable behaviour. The main components of such programmes are similarly identifiable but as in other areas of therapy they encounter the problems of controlling for spontaneous remission effects, and in any event their principal therapeutic value may be due to affiliations with an adult who can act as a stable model. However, it may well be that the most powerful emerging technology is that of systems intervention now beginning to form a practical base for community psychology.

Training

The most obvious implication of an interdisciplinary approach for training is that at least some of it should occur in an interdisciplinary setting and should promote interdisciplinary communication. One positive feature of current behaviouristic technology is that it tends to provide a medium for discussion.

Other than this I offer the following remarks about training which stem from a systems viewpoint. These are that professionals seem to be increasingly involved in training others to provide primary services; that their roles and functions are progressively involved in programme or service design: and that, often unwillingly, they are being drawn towards system intervention and management. Training is only just beginning to recognize these professional realities.

(d) Evaluation

The rapid tempo of change in special education together with changes in the planning and management of community services has attracted attention to the evaluative aspects of service delivery. A number of procedures are available or are being developed (compare Stufflebeam, 1973); but as a synthesis of a number of approaches I would propose the following general categories:

1.a	(Direct)	probability	of identification of target population
		probability	of delivery of service
		probability	that service is accepted
		probability	that service is effective
1.b		probability	that the service is cost-effective by accepted economic standards.

Together the components of (a) and (b) compose an evaluation in terms of optimalization of resources. However, at least two other aspects can be assessed as -

2 (Indirect)

a. effects upon adjoining sub-systems

b. effects upon adjoining systems

and

3 Relationship to community value systems and the policies to which they are related.

1.a Identification or definition of target populations is from an interdisciplinary point of view a difficult and historically contentious task. Even in the reasonably clearcut areas of developmental disability any children remain unidentified in either a deliberate act by parents or sheer ignorance of where to obtain help. The need for a contained medical, educational and social welfare approach is apparent in the early diagnosis, screening and intervention of the handicapped, particularly if institutionalization is to be avoided. It is difficult, however, to apply a similar model to the general field of learning disabilities since the numbers involved are so large and the target populations vary according to contemporary definition; but the lessons of "Head Start", "Home Start", and "Follow Through"

in the U.S. leave no doubt that intervention must be total in the area of disadvantaged poor children. The category of emotional disturbance traditionally causes difficulties, primarily because of behavioural definition and the association of disturbed behaviour with other conditions and in any case a very high likelihood of spontaneous remission. In the situation of scarce resources the concepts of accuracy and acceptance of delivery are perhaps more significant but in all circumstances the issue of effective service arises. And here it must be conceded that the exercize of major responsibilities have often been patently unsuccessful. I think now of the treatment of emotionally disturbed and of delinquent children by social welfare and correctional services; the medical care of severely retarded children and the inability of the regular education system to cater for depressed minority groups are illustrative of a serious social problem. Often this has been complicated by a somewhat competitive and selective attitude to target populations.

1.b The intrusion of cost benefit assessment into the provision of social services is inevitable and represents, perhaps, one more step along the road to a fully systematic evaluation using the methodology of operational research. It is fair to say that although several workers have realized the potentiality of these approaches (Budde, 1972; Zifferblatt, 1973), their application in real life situations is in its infancy.

2 Indirect effects

Competition for resources has obvious effects within sub-systems: the expensive special school can markedly inhibit efforts to set up, say, teamwork approaches to mainstreaming elsewhere in the special education system. Perhaps more dangerous, however, are the subtle indirect effects upon neighbouring systems, for example, when a social welfare agency closes down its residential facility in furtherance of a concept of community care but does not build up the necessary support services. Frequently the result has been an overloading and distortion of psychiatric and educational facilities.

3 Relationships to community value systems are of considerable interest in that reasonably effective services may now be defined as incompatible with the concept of normalization. Conversely services may be ineffective but fit in with the community's incoherent but nevertheless well meant attempts to care for its more unfortunate citizens. The growth of remedial teaching resources amply illustrates this point. There has never, to my knowledge, been a substantial body of evidence which would justify the setting up and maintenance of remedial services in terms of positive educational gains. However, many influences have joined to promote the concept, as witness the evidence given to the recent House of Representatives Select Committee on Specific Learning Difficulties, A.G.P.S. (1976).

An important consideration in both general and special education is its capacity to promote change but clearly this is extremely difficult to formalize and quantify.

(e) Creation of new approaches

The high cost of social, educational and health services within advanced communities has continually forced a reappraisal of the nature of primary service delivery. Thus, agencies are engaged in redefining their primary service packages and the professional or paraprofessional roles and functions which will facilitate their delivery. This can involve the creation of a new interdisciplinary type of training which draws upon a number of bodies of professional knowledge. In the field of severe retardation for instance, Bricker's idea (1971) of the educational synthesizer using concepts from medicine, nutrition, psychology, psychotherapy, speech therapy, etc., is apposite. In the area of delinquency or pre-delinquency the idea of the teaching parent, as exemplified by Achievement Place (compare Wolf et. al., 1972) makes a new departure in child care, as does the 'educateur' principle evolved by Linton (1969): the notion of a professional parent of graduate status trained in a range of child rearing competencies.

A second related method is to promote interchangeability of roles, a concept which has flourished particularly well discretely but often in the area of services for maladjusted children. Here the most skilful agent in family intervention may prove to be the psychiatrist rather than the social worker in individual therapy; in individual therapy the psychologist rather than the psychiatrist and in behavioural technology the social worker rather than the psychologist.

The general areas of learning difficulty and social disadvantage have made prominent use of parents, peer groups and various forms of paraprofessional aides. This will inevitably grow as a result of the availability of quality tested package programmes such as DISTAR.

2 New forms of interdisciplinary organisations

The principle of interdisciplinary organisation has taken many forms, facilities being developed so as to epitomize the approach in its own right and to resolve the areas of interface between delivery systems. Typical manifestations are the diagnostic clinics, hospital or community based which tend to flourish in times of comparative affluence. Such agencies represent a very high cost concentration of resources and in my view should incorporate exemplary service delivery, both diagnostic and programmatic; training and dissemination and possibly research and development functions. Many of these functions can be described as forms of general technical assistance to delivery systems.

We are currently examining some exemplary aspects of service delivery in the context of an interdisciplinary based work preparation centre (compare Ward et al, 1977) and other projects associated with the Special Education Centre at Macquarie University. In

this, the Centre possesses similarities to the University Affiliated Facilities which have been developed to promote the growth of services to the developmentally disabled in the U.S. (compare Tarjan, 1976). Here it has to be conceded that the discipline of medicine has clearly the most developed and longstanding expertize in providing centres of excellence via exemplary service, teaching and research both pure and applied. The most outstanding research centres, both in the U.S. and elsewhere have capitalized upon this.

Research

The following are suggested as forms of research which, irrespective of the nature of funding or their institutional basis, require interdisciplinary advocacy.

1 Longitudinal research

Although the expense and management difficulties of longitudinal surveys are immense I believe that there is no substitute for such studies as the National Development Survey in the U.K., e.g. Davie, et al. (1972), and that a similar project is mandatory for Australia. In view of the increasingly complex multi-cultural nature of Australian society, central data collection as to normative physical, educational and social characteristics of its children would be invaluable as an aid to policy formation at all levels. Thus, study generates and supports a very wide variety of researches and would go some way to remedy the specific lack of usable data currently evident. In the long run a similar approach to specific groups is also desirable: Down's Syndrome, the retarded in the workforce and those who are institutionalized on a long-term basis for whatever reason, etc.

2 Longitudinal Programmatic Research

Allied to research of the type outlined above is longitudinal work in which target populations may have received planned intervention: medical, psychological or social. This is typified by Head Start, or Follow Through programmes in the U.S. and provides cumulative evidence as to the effects of various forms of decision making.

3 Basic Research

The need for fully interdisciplinary research is obvious from consideration of both normal and deviant child development. Up to 6% of children possess one or more potentially significant medical conditions: very large numbers of children are at some form of social and educational risk. A personal view would be that the more severe the handicap the greater the level of inter-disciplinary intervention. At the moment we are, however, suffering from a lack of instrumentation of all kinds, in the field of multiple handicaps.

4 Developmental Research

Over most areas of exceptionality there is a need for development work in producing technologies, programmes and strategies. These may need validation in different types of institution and use by varying delivery systems. A limitation in this would be the expense of producing programmes especially when high quality overseas materials exist and would need very little modification for Australian use. Development of materials is probably best carried out in the context of technical assistance programmes. These may incorporate exemplary classrooms and opportunities for highly controlled field trials under conditions in the less controlled field situation. On this point it is worth commenting that although high levels of technical and experimental controls have been achieved in bringing about behavioural changes, educationalists are faced with the perennial problem of generalization of behaviour: this lack of generalization is most evident in severe retardation but applies similarly to much treatment of emotional disturbance and delinquency. Stokes and Baer (1977) have recently contributed a timely review of the topic.

5 Research into the planning and management of service delivery

Besides the task of basic data to which reference has already been made, I believe that the valuable experience gained in military organisation, commerce and industry and all forms of resource management, is insufficiently represented in contemporary thinking. Whilst it is to be hoped that a purely economic view of service delivery would not prevail, some concept of cost effectiveness is necessary and, when achieved, as in estimation of institutional costs versus community care, or work preparation costs versus pension costs, can form very powerful arguments for change. Incidentally I have argued elsewhere, Ward (1976), that the variations in service delivery occasioned by the Australian State system offer superb opportunities for planned comparisons in this regard.

Conclusions

Despite my belief that the contributory disciplines of education will supply the main impetus towards positive change, I hope that this paper has not demonstrated an overly parochial view, and that the consideration of service delivery which forms the bulk of its content represents a useful form of systems approach. Within this reference to technology necessarily occurs as a consequence of the formal method of analysis, but I would note once again a wide range of viewpoints as to the status of behavioural technology. In particular, these vary from the firm belief that the technology now exists for most purposes to the view that technology is still rudimentary. Between these extremes many see the problems as being ones of design rather than a lack of basic technology. However, most would agree

that there exists a firm base in community attitudes and technology for all disciplines, systems and community agencies to promote and realise positive goals for the handicapped. In order to gain maximum political and economic support for these ends, they should seek to maximize their contribution to effective resource management and the delivery of services with which they are associated. This should involve participation in the further development of efficient technologies and programmatic design, resulting in truly interdisciplinary data base. Interdepartmental and interdisciplinary course content and practicum experience should be present in most, if not all, forms of training for work with exceptional children and should lead to maximum opportunities for informed joint efforts and the creation of new approaches. For in the long run it will be efficient service delivery which determines the quality of life for the exceptional child and which will prove to be the most significant and obvious form of advocacy.

REFERENCES

ABT Associates Inc. (1977) *The Follow Through Planned Variation Experiment*, Volume 11-A National Evaluation: Pattern of Effects. Washington D.C.: U.S. Department of Health, Education and Welfare.

Australian Government Publishing Service. Report of the House of Representatives Select Committee on Specific Learning Difficulties (1976) *Learning Difficulties in Children and Adults*.

Andrews, R.J. (1975) Multi-disciplinary models in special education? *The Exceptional Child*, 22, 1, 45-57.

Bricker, D. (1976) *Educational Synthesizer*. Unpublished manuscript, Mailman Center For Child Development, University of Miami.

Budde, J.F. (1972) Will Institutionalisation Survive? A System View of Redeveloping Program for the Retarded. *Mental Retardation*, 10, 24-28.

Cruickshank, W.M. (1974) The False Hope of Integration. *Slow Learning Child*, 21, 2.

Davie, R., Butler, N. and Goldstein , H (1972) *From Birth to Seven*. National Children's Bureau, London: Longmans Green

Gallagher, J.J. (1972) The Special Educational Contract for Exceptional Children. *Exceptional Children*, 38, 527-535.

Kaufman, M.J., Gottlieb, J., Agard, J.A. and Kukic, M.B. (1975) Mainstreaming towards an explication of the construct. In Meyen, E.L. *et.al.* (eds) *Alternatives for Teaching Exceptional Children*. Denver: Love Publishing.

Keogh, B.K. (1975) Social and Ethical Assumptions about Special Education. In K. Wedell (ed.), *Orientations in Special Education*, 1-16, London: Wiley.

Linton, T.E. (1969) The European Educateur Program for Disturbed Children. *American Journal of Orthopsychiatry*, 39, 1, 125, 133.

Mittler, P. (1976) Summary of Evidence Presented by the British Psychological Society to the Enquiry into Special Education set up by the Department of Education and Science. *Bulletin of British Psychological Society*, 29, 1-6.

Public Law *Developmentally Disabled Assistance and Bill of Rights Act* PL 91-517. Amended as PL 94-103.

Skinner, B.F. (1953) *Science and Human Behaviour.* New York: Macmillan Co.

Skinner, B.F. (1968) *The Technology of Teaching.* New York: Appleton-Century-Crofts.

Stokes, T.F., and Baer, D.M. (1977) *An Implicit Technology of Generalization.* The University of Manitoba and The University of Kansas.

Stufflebeam, D.L. (1973) An Introduction to the P.D.K. Book Educational Evaluation and Decision-making. In B.R. Worthen and J.R. Sanders (eds.) Educational Evaluation: Theory and Practice Washington, Ohio. C.A. Jones Publishing Co.

Throne, J.M. (1973) Normalization through the Normalization Principle: Right Ends, Wrong Means. Unpublished Paper. Lakemary Centre for Exceptional Children, (University of Kansas).

Ward, J. (1975) Behaviour Modification in Special Education . In K. Wedell (ed.), *Orientations in Special Education.* London: Wiley

Ward J. (1976) Unpublished report to the Schools Commission on Educational Needs of Children in Institutions.

Ward, J., Parmenter, T., Debenham, D. and Miller, V. (1977) Vocational Preparation for the Mildly Retarded - an Investigation into Employment Patterns and Related Factors. *National Rehabilitation Digest*, 1, 29-45.

White, O.R., and Haring, N.G. (1976) *Exceptional Teaching.* Columbus, Ohio: C.E. Merrill.

Wolf, M.M., Phillips, E.L. and Fixsen, D.L. (1972) The Teaching Family: a New Model for the Treatment of Deviant Child Behaviour in the Community. In S.W. Bijou and E. Rikes-Inesta (eds.), *Behaviour Modification : issues and extensions.* New York: Academic Press.

Wolfensberger, W. (1969) The Origin and Nature of our Institutional Models. In R.B. Kugel and W. Wolfensberger (eds.) *Changing Patterns in Residential Care for the Retarded.* Washington: Presidents Committee on Mental Retardation, 59-172.

Zifferblatt, C.E. (1973) Behaviour Systems. In C.E. Thorensen (ed.), *Behaviour Modification in Education.* Seventy-Second Yearbook of National Society for Study of Education. Chicago, III: University of Chicago Press.

CHAPTER 5

COLLABORATION BETWEEN MEDICINE, EDUCATION AND WELFARE IN THE INTERESTS OF CHILDREN : A SOCIAL WELFARE VIEWPOINT

Edna Chamberlain

It is unlikely that I can say anything about collaboration of medicine, education and welfare in the interests of children that has not been said already in discussion of the medical and educational viewpoints. For we are all looking at the same phenomena and the lens we use serves to focus what we hold directly under the microscope while not dissociating it completely from the blurred periphery. It was once the practice at seminars such as this to try to sharpen up the edges, to draw the boundaries of the various professions in an effort to differentiate roles and functions. Now there is more acceptance of the blurring and it has become fashionable to see it as not only inevitable but functional. It is the blurring of perspectives that facilitates a comprehensive view of the child in his social context and, if the children's interests are paramount, then the criteria for who-does-what-and-when exist apart from the aspirations or vested interests of particular professions. But noble sentiments do not always survive the test of practice, as is manifest most commonly in clinical teams in guidance and health centres. While I shall get to methods and issues of collaboration at that level eventually, I should like first to address the question of collaboration at the broader levels of policy development and program administration. My theme will be that, as important as it is to solve the dilemmas of the team approach in delivery of special services to those who need them, it is even more important to effect collaboration to ensure the provision of general living conditions which will minimize the need for special services.

The expressed values and goals of medicine, education and welfare are strikingly similar. All envisage a state of physical, mental and social well-being as the right of every person and aim to assist in the optimum realization of each one's potential. In these global terms the view is holistic. In this seminar we have already broken down the holistic vision on one dimension, that of age, by specifying the rights and interests of children, though we have avoided breakdown on other dimensions such as race and ethnic origins: We clearly mean children whether black or white, Greek born or fifth generation Australians. However, since we are here to talk about collaboration, we have tacitly admitted a breakdown of the holistic vision on another dimension, problem area, a breakdown which has resulted in professionalization and further specialization within and across professions. There has, of course, been good reason for such

specialization. For the holistic view, while conceptually comparatively simple, is an extraordinarily complex one to work with. The process of specialization has fostered knowledge building and enormous advances in technology in the human services, as well as in science. Unfortunately, it has also fostered compartmentalism. Collaboration, the process of bringing it all together again, becomes itself a speciality, with sound conceptual underpinning and many fervent followers though, as yet, an uncertain methodology.

There may be some value in trying to communicate diagrammatically the three levels at which collaboration is, in my view, necessary (see Figure).

The diagram could be seen as a conceptual model (left-hand side) or an organizational one (right-hand side).

I intend to focus on actual practice represented on the right-hand side but I do so in the conviction that we can only improve actual practice by relating it at each level to the holistic vision of children's interests with which we begin and which - having broadened our range, deepened our understanding, and sharpened up our methodology by specialization - we try to replicate for any particular child we meet face to face.

Before discussing each of the three levels of collaboration, however, I need to say briefly what I would see as conducive to the best interests of children. On the assumption that the family or some other group (irrespective of structure and the role relationships of its members) is required for primary nurturing, the first necessity is a range of policies to support the family. A platform of basic support services would include:

Income security for the family
(preferably through employment programs, with assurances of a minimum income level through a system of benefits and pensions if parents are precluded from the labour market);
Adequate housing;
Ready access to health services;
Opportunities for appropriate education;
A range of constructive facilities for leisure and recreation; and
Protection of civil rights through legislation such as Family Law and the Childrens Services Act.

To supplement the family, when necessary, a range of services such as family counselling, day-care, after-school care, domiciliary services (home care and housekeeper services) and community services for children and youth, needs also to be available. And, in the last resort, substitute care services such as foster care and institutional care need also to be available.

CONCEPTUAL MODEL

Holistic Concept

Specialization

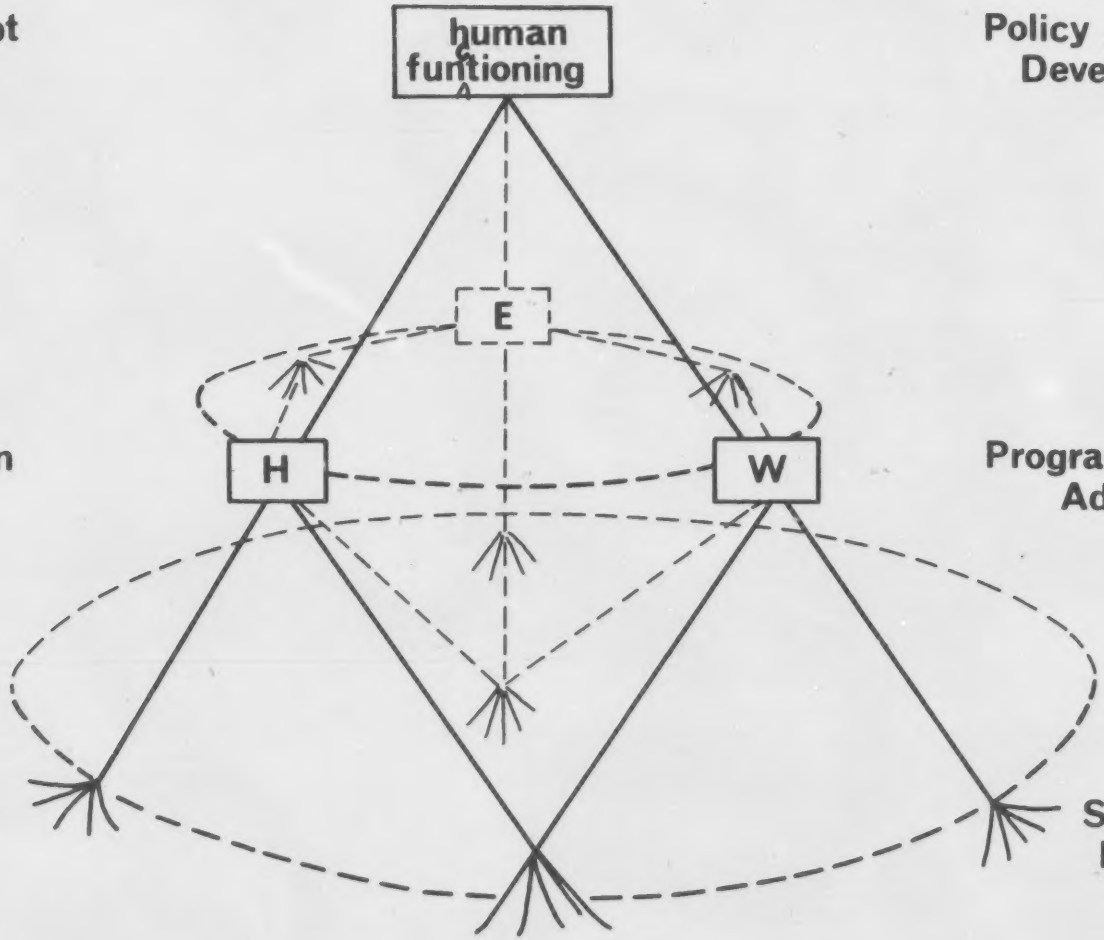
Team Concept

ORGANIZATIONAL MODEL

Policy Development

Program Administration

Service Delivery



Policy Development

Although I have just itemized a basic platform of acceptable child care, I take the broad view of welfare as manifest in all those social provisions which have to do with living conditions and the quality of life. I accept the more technical definition of welfare, as concerned with the provision of resources for those whose opportunities to control their own social functioning are limited by deprivation or handicap, as reluctantly as a public health doctor or community health practitioner accepts that medicine is simply concerned with the treatment of disease or disability, and as an educator would that his skills are required only for remedial teaching or even merely for teaching. To accept these narrow definitions is to overlook the role of the professions historically and contemporarily in *promoting* health, education and welfare and in preventing breakdown. The great advances in the last century in the developed countries have resulted "in the last analysis from improvement in the economic situation, living conditions and nutrition of the masses of people" (Ryan, 1976). I take this quote from a paper on health but it might equally be made as a tribute to welfare. Names of persons who campaigned for social reform, such as universal education in the latter part of the 19th century and universal health coverage in the latter part of the 20th century appear or will appear in the histories of social welfare as well as in histories of education and medicine (or for that matter in histories of mankind). The point I want to make here is that there is a convergence of interest at the philosophical and ideological level.

In practice top-level policy development is a matter for politicians and civil servants more than for academics, professionals and idealists (though there is some overlap of categories). As I have commented elsewhere:

> "*.....political decisions ultimately determine our directions: firstly the decisions made at the polls, secondly the decisions made in Cabinet in relation to proposed policies and programs and thirdly decisions made by Treasury. The Budget, better than any Commission report or departmental submission or political speech, tells us what the priorities are; not only how much money is to be spent on social services but how much in relation to expenditure on other services, and what kind of relationship the Government envisages between the various areas of expenditure. The Budget embodies the welfare goals of Australians. It does so not only through its specific provisions for social welfare programs and social services in the narrow sense. It does so through its methods of collecting revenue, particularly the taxation system, on the one hand, and its overall allocation of resources on the other. Not only are its provisions for health and education*

> *relevant to welfare, so are its provisions for economic programs, regional development, primary industries and all the rest. In the present climate programs to combat unemployment are readily recognised as welfare."*
> (Chamberlain, 1975).

This is important to mention because it implies that collaboration in the interests of children requires a commitment and a methodology for getting input into the system, at the top, so that *all* policies are reviewed in terms of their contribution to the promotion of the optimum living standards economically feasible, that compensatory programs for disadvantaged groups are carefully coordinated with one another and with overall policies and programs; and that all such programs are adequately funded.

I hope that you have not already consigned that level of collaboration to the too-hard basket because difficulties are multiplied in the Australian scene. Though Federal Government funding is of major significance, health, education and welfare are state government responsibilities and, whether or not the devolution strategies recommended by the Task Force on Co-ordination in Welfare and Health (the Bailey Report) are implemented, any collaborative exercise has to be repeated in relation to the allocation of the state budget. Increased funding of the human services generally and appropriate allocation over the various services are clearly necessary targets for collaborative action in Queensland.

The most common formal mechanism by which individuals, groups and organisations (including the professions) from outside government can influence policy is through consultative or advisory councils. It is interesting to note that some councils which already exist do seek collaboration between medicine, education and health irrespective of the particular area of focus. For example, the State Advisory Council on Special Education includes a doctor and a social worker along with educators. Of course, opportunities have to be sought outside such formal channels, and organizations like the Queensland Council for Social Services serve a function in bringing together professionals concerned about certain issues (not only in relation to children) so that co-ordinated submissions can be made. I recognise that competing interests among professions (at this level as at the clinical or team level) have often to be resolved, but this is where the resolution has to take place if the policy-makers are to be persuaded. I say this on the assumption that the criteria we are using are in the best interests of children, not in the best interests of the professions or disciplines.

It is further interesting to note that the Bailey Task Force is currently engaged in a round of consultations on the possible future processes of consultation. I know several individuals and groups have put before the Task Force

their recommendations about opening up consultative channels with the policy makers. To what extent was this seen as a possibility for collaboration? Did health and welfare groups get together to put up joint submissions? The government departments with responsibilities for health and welfare respectively are concerned mainly with program administration, at which level specialization would seem appropriate. Unfortunately, though unnecessarily, this seems to militate against collaboration.

Program Administration

You will recall that, in my diagram, I used the letters H E W (H for 'Health' rather than M for 'Medicine' as specified in my title). This is no doubt because of my familiarity with the United States Department of Health, Education and Welfare. I refer to it here because I used to be impressed by the apparent sophistication of United States policy makers who seemed able to operationalize the concept of collaboration not only at the level of policy but also in program administration. However, when I visited HEW in Washington D.C. and presented myself at the large building so labelled on one side of the Capitol, it turned out to house Health personnel only and the Welfare personnel I wished to see were in another building on the other side; and, of course, there was yet another building for Education. So for purposes of program administration there was no more closeness geographically or operationally than similar buildings in Canberra or in Brisbane. The personnel of each section consisted of bureaucrats and persons from the core profession, though a scattering of persons from other professions provided some opportunities for collaboration internally; just as, for example, the employment of some social workers in the Queensland Health Department offers some minimal potential for internal collaboration. The major collaborative mechanism at the program administration level is the inter-departmental committee and/or ad hoc conferences and seminars, as well as informal meetings between members of various departments. However, collaborative efforts from outside are possible and necessary. While a holding to one's professional association or colleagues offers supports on certain issues, cross-professional meetings outside the system provide opportunities for understanding one another's viewpoint and underpinning collaborative efforts within the system.

Service Delivery

At this point I am going to shift gears. Program administration covers an array of services. I am going to assume you are familiar with the pattern of services offered by various state government departments and voluntary agencies for children in Brisbane.

In moving to service delivery, we leave behind the interests of children in the abstract and look to the interests of particular children. I want to introduce you to Mary Smith and Tommy Jones not because they embody between them the full range of possibilities but because each typifies one of the two major kinds of collaboration at this level:

> *Mary Smith (aged 8) is the only child of middle-class parents; her father manages a large commercial firm and her mother was a teacher. During the Christmas holidays in 1976 the family car driven by Mary's mother was involved in an accident. The parents were unhurt but Mary suffered a head injury, thought to be minor at the time. Recently Mary's mother brought her to a Child Guidance Clinic, on the advice of Mary's teacher, reporting emotional tension, stumbling speech and, in her mother's words "her reading skills appear to have stopped". The teacher reported a speech and reading difficulty which she believed pre-dated the injury. Also Mary's teacher believed there might be some tension at home centred on Mary. Mary was referred for diagnostic testing and neurological assessment.*

The situation represents a not unfamiliar clinic presentation. The clinical team - doctor, psychologist, speech therapist and social worker - will proceed with various tasks according to precedent at that particular clinic. The information will be collated and judgments made about disposition of the case. This may be done by the "team leader", almost certainly the doctor, either alone or with an audience, that is in case conference. Too frequently sharing at case conferences is of information only, not of decision-making. The case conference may of course be of the more open kind with treatment decisions emerging as they are crystallized in discussion. I may seem to be implying this latter kind is always best but I am not unaware of the hazards implicit in the notion of "shared responsibility". I quote from a publication on "The Hazards of Teamwork":

> *"The myth that the total team is effectively discharging responsibility for a given patient may mask the fact that no one fully accepts responsibility or feels himself to be ultimately accountable for what happens."*
> (Rae-Grant and Marcuse, 1968).

I do not wish to dwell on this or other hazards of teamwork such as:

> Lack of trust in the professional judgment of others;
> Lack of knowledge about or appreciation for the philosophic values and professional competencies of other disciplines and occupations;

The status of long-established and revered professions alongside that of emerging occupations aspiring to higher status;
The issue of domain;
Differential definitions of "the team" and the implications of 'follow-the-leader' in the very concept of team; and
Ideological/theoretical splits which cut across the disciplines (for example, the psycho-dynamically oriented team members lining up against the behaviourally-oriented ones).

I anticipate these issues will be pursued during the course of this seminar, as they have been and will be at many others. Like others among you, I have some ideas about measures for minimizing these hazards but I shall reserve comment on them for the moment as I have chosen to address collaboration (and therefore a facilitative methodology) at a much broader level than that of the clinical team.

I have not, however, said all that I wish to say about service delivery. In Mary Smith's case I mentioned as members of the team only those employed within the clinic. Almost certainly Mary's teacher would be contacted as a source of relevant information. Is she, however, to be regarded as a team member participating in the decision for treatment? Almost certainly she will be seen as a potential change-agent - to carry out the clinic's recommendation or one she has helped to formulate? And the parents? Certainly, they will be significantly involved as sources of information, possibly as change-agents to assist Mary and possibly as targets of change. It's almost equally certain they will not be seen as team members though there is a growing literature supporting the concept of consumer involvement in decision-making relevant to their well-being (Benn, 1977). I am tempted to digress on this issue but accept the boundaries imposed by my title which does not include parents among the collaborators in the interests of children. In registering my protest I should say I have not overlooked that the keynote address of the seminar was scheduled as "Parent involvement in the Health, Education and Welfare of their children". I hope they were seen as partners, of at least equal importance as are professionals.

I want to introduce now Tommy Jones. It may be possible to perceive narrowly the collaboration necessary in the interests of Mary Smith as that taking place behind the closed doors of the clinic. I want to contrast this situation with the kind of collaborative efforts required in relation to Tommy Jones.

"Tommy Jones, an undersized boy of 10 years, lives with his mother and four younger children, three brothers and baby girl whom his mother "fosters" - a private arrangement for a teenaged neighbour who became pregnant at 14 years.

His mother says his father left home six-and-a-half years ago though the youngest boy is only five. They live in a small house still dank after flooding in 1974, in a depressed area on the outskirts of Brisbane. In the eleven houses in the block, only one family is intact with both parents present. Tommy's mother receives a pension which she augments by working three evenings a week cleaning a local store. Tommy is expected to look after the young children on these occasions and is fairly responsible about the baby though he sometimes goes off if she is sleeping. Also, he sometimes "belts up" younger brothers especially the five-year-old who is a wan child with a whining manner. Tommy's school performance is poor. The teacher suspects some hearing loss though it is hard to tell whether he just doesn't bother to respond as he seems to hear when with his friends. He misses school frequently. Since his friends are also absent on such occasions, the teacher suspects truancy but his mother always "sticks up for him" and says he was helping her at home. She admits, however, that she is afraid his friends, two of whom have been charged with vandalism, will lead him into trouble. The school is a small one, technically "disadvantaged" and it has suffered a rapid turnover of teachers in the past two years, Tommy's class being affected more than most as a teacher "doubled up" with his class and the one below for several weeks early this year. There is no remedial teacher at the school.

Tommy's situation is considerably more complex than Mary's. For this reason alone Tommy is more likely than Mary to be a victim of "shared responsibility" with no one effectively pursuing his interests. Our efforts still tend to be directed towards the marginal child rather than the ones grossly deprived. I believe that the prime responsibility for Tommy is with the discipline of social work since the major difficulties would seem to be social rather than personal and familial. The family is devoid of normal supports, there being inadequacies in income, housing and educational resources. There are health problems associated with nutritional deficiencies; poor resources for leisure and recreation; and a need for supplementary services, either by way of further income so that Mrs. Jones need not do part-time work in the evenings or by way of home care services for the children while she is absent. Moreover, review of the situation in relation to the "fostered" baby may be indicated. In the face of these extended social ramifications special education, if attempted, would seem doomed to failure. In fact, any measure focussed on any one of the Jones family problems or even several measures aimed at all the problems, one by one, will be at best palliative and at worst exacerbating. Rather, active collaboration between representatives of a variety of social agencies as well as health and education

facilities would seem essential. Several features about such collaboration would seem to distinguish it from that required for Mary Smith.

(1) The community base for action as distinct from the clinical setting for Mary Smith's collaborative team (necessitating a host agency open to the community and free to use its findings);

(2) The variety of interventive processes required to link the Jones family with potential resources (necessitating both mediation and advocacy); and

(3) The limitations of existing resources and provisions (necessitating collaborative social action to effect policy and program development).

Problems imbedded in the social structure such as poverty and its associated ills have to be attacked at the societal level.

I have come full circle round, not only to a holistic view of the person, Tommy, but also to the need for a convergence of values and goals in ideological terms, a unitary conception in theoretical terms and, in terms of practice, collaboration at every level to achieve general policies, and compensatory ones for special groups, which will optimize living conditions for all members of the community.

Collaboration has emerged as a speciality but goes far beyond working together in clinical teams.

I want to conclude with a comment on methodology for the new speciality of collaboration. Collaboration demands more than anything else interpersonal skills. It is argued that there will be more collaboration if members of different disciplines understand better each other's objectives; know more about each other's content areas; share classes and tutorials both as educators and students; meet on common tasks, e.g. in practicums at undergraduate level; meet in seminars on shared concerns, and informally just to get to know one another better. I would applaud all of these procedures. Yet all are based on an assumption that the individuals concerned will use what interpersonal skills they possess to communicate better with each other across disciplines. The assumption is challengeable. Many of us, young and old, rank low on interpersonal skills, have acquired modes of interacting both offensive and defensive which impair communication. An essential component of interdisciplinary education or education for the human services would be a course aiming to teach interpersonal relationship skills. Several such courses have been reported in the literature, e.g. Hollister and Edgerton, 1974, and they are a feature of many existing professional courses such as social work, educational counselling, and clinical psychology.

However, while interpersonal skills are necessary to facilitate communication we first have to want to communicate. We will want to communicate -

Firstly, if the central commitment to the best interests of children becomes more than a philosophical conviction, more than a theoretical concept, but rather an operational objective;

Secondly, if we carefully assess the full range of health, educational and social barriers to optimal development of children to determine the key points of intervention; and

Thirdly, if we agree to direct our collaborative effort at those points.

Finally, if our determination to intervene at those points outweighs all considerations of aggrandizement of the role, function and status of particular disciplines.

References

Chamberlain, Edna. "Trends in Social Service", *Australian Social Service*, June, 1975.

Concetta, Benn: "A Study of the Development of Consumer Participation in the Family Centre Project, A Demonstration Anti-poverty Program of the Brotherhood of St. Laurence". Unpublished Master's Thesis, University of Melbourne, 1977.

Hollister, William G. and Edgerton, J. Wilbert: "Teaching Relationship Building Skills". *American Journal of Public Health*, January, 1974.

Rae-Grant, Quentin, and Marcuse, Donald: "The Hazards of Team Work", *Journal of Orthopsychiatry*, January, 1968.

Ryan, J.G.P. "The Health Team: Myth or Reality?" Elkington Oration, Brisbane, 1976.

CHAPTER 6

IN LAW, THE INTERESTS OF THE CHILD SHALL BE PARAMOUNT : A VIEWPOINT

Quentin Bryce

This paper is presented as part of a seminar about children - their health, education and welfare, because the author ascribes to the statement of value contained in the preamble to the Declaration of the Rights of the Child that "mankind owes to the child the best that it has to give". With respect to the child and the law, the second principle of that Declaration states "that the child shall enjoy special protection and shall be given opportunities and facilities by law and other means to enable him to develop mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity - in the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration".

References to the protection and promotion of interests of the child have appeared in legislation concerning children for many years now in the common law world. Have we become so accustomed to them that we have come to assume that when the law intervenes in the child's life, the child's interests are in fact paramount? It is the purpose of this paper to examine how the best interests of the child are served in three areas of legislation, (1) the juvenile justice system, (2) adoption and (3) custody.

(1) *The Juvenile Justice System* is governed by the Children's Services Act - the aims of which are "to promote, safeguard and protect the well-being of the child and youth of the State through a comprehensive and co-ordinated program of child and family welfare". The major statutory authority used for this purpose is the Children's Court, the most significant jurisdiction of which is to -

(i) hear and determine legal proceedings against juveniles (under 17 at the time of committing an offence);

(ii) hear and determine applications for care and protection and care and control regarding a juvenile.

" The institution of the children's court is a product of the success of the movement directed towards the removal of children from the processes of the ordinary criminal law. Essentially the philosophical position of the reform movement was that there should be no distinction between the delinquent and the neglected child. A child who

> committed an offence should not be treated in the same way as an adult criminal offender. Instead he should be regarded as a youngster in need of help as an understanding parent would a difficult child. In no sense was the child an outcast from society. On the contrary he was to be held the child of society, to be given the help and care which society can give." (Cairns, 1975).

The theory is to protect the child from social conditions that led to the wrong-doing by providing care, guidance, and understanding. Such a philosophy resembles in its most important respect the parens patriae doctrine of the ancient chancery jurisdiction over children.

That approach looks to welfare and best interests as of paramount consideration. It is because of that, that the strict criminal procedure in the adult jurisdiction was not necessary for juveniles. However it is doubtful that the standard of service being delivered to the child in the name of this approach is serving his best interests. Mrs. Foremann in her work *Children or Families?** points out that a failure to appreciate that the philosophy of the juvenile court was developed to counteract some of the more primitive and unsuitable features of adult court, has caused a deviation from the principles of justice.

The informalizing and personalizing of the court have acted against rather than in favour of the child - Queensland is not alone in this situation. In many jurisdictions the results of similar courts have not been wholly satisfactory. Judge Fortas in *Kent v. U.S.* said "There is evidence that the child receives the worst of both worlds that he gets neither the protections accorded to adults nor the solicitous care and regenerative treatment postulated for children. The Supreme Court of United States stated in its watershed decision in the area of minor's rights in 1966 re Gault "Juvenile history has again demonstrated that unbridled discretion however benevolently motivated is frequently a poor substitute for principle and procedure".

In this case a fifteen year old boy was accused in a verbal complaint of making obscene phone calls. As a result two hearings were held. At these hearings no witnesses were sworn and the accusing witnesses were not present. The juvenile's parents weren't notified of the hearings, no record of either hearing was maintained and there was no notification of a right to counsel. As a result of this informal process, Gault was committed as a juvenile delinquent to the State industrial school for the duration of his minority - a time amounting to 6 years. The realities of the situation were emphasized by the Court - solely because he was under 18, the defendant was subject to a long period of confinement.

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* Australian Government Social Welfare Commission.

The court noted the irony of the fact that had Gault been 18, the maximum punishment for making obscene phone calls would have been $50 fine and two months imprisonment.

It was insignificant, the court felt, that the institution to which Gault was committed was called a school rather than a prison. The institutional hours, regimentation and white-washed walls to which the defendant would be confined for 6 years amounted to incarceration and the loss of liberty.

The court found that due process was unjustifiably denied the defendant simply because he was a juvenile. "Under our Constitution the condition of being a boy does not justify a kangaroo court".

The juvenile needs the assistance of counsel. Since this decision the Supreme Court has consistently confirmed its holding that children cannot be denied constitutional rights because of their minority. An excellent collection of samples is provided by Kenneth Wooden in his disturbing book "*Weeping in the Playtime of Others*" (McGraw Hill, 1976).

Section 21 of the Children's Services Act provides that the provision of the Justices Act 1886 - 64 shall apply to -

(1) the institutions and conduct of a proceeding before a children's court;

(2) the exercise by a children's court of its powers, authorities and jurisdiction.

Thus the court is required to proceed with regard to the legal forms of a magistrate's court. However in the name of individualized justice, informality and personalization there is a lack of regard for court procedure.

May we pause to glance at the court, closed to maintain confidentiality but not to prevent scrutiny of methods of dispensing justice to juveniles.* Section 25(3) of the Act provides for the venue of hearings - presently at centres such as Holland Park, Sandgate, Wynnum, Redcliffe and Inala. The court for the Central Brisbane area is situated within the confines of Wilson Youth Hospital at Windsor - an institution used as a remand centre, a psychiatric assessment centre, a detention centre or jail for children. While it is convenient to have a children's court adjacent to the remand centre it is pertinent to question the effect

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* There has been little research in this area in Queensland. The Queensland Council of Social Service and the Justice for Juveniles Group are presently collecting data. I acknowledge their assistance in the preparation of this paper.

of the closeness of the court and the incarcerating institution on the attitudes of children and parents.

Would our society tolerate adult offenders having their cases heard in the confines of Boggo Road Jail?

Through the proceedings it appears that in this court time is of the essence. Cases are heard at amazing speed - as many as 30 cases in a single morning. Even though the magistrate never formally convicts, if the defendant is found guilty, for statistical purposes, the Police Department counts it as a crime solved and credit is given to the Police Officer concerned. Severe pressures can be put on the child e.g. by a policeman to plead guilty to the charges given in court, or by parents wanting to be rid of their burden who hope that the State will take the child from their custody, out of the way of their own lives.

Most issues like the necessary references to legal aid are passed over quickly. The child and his parents are confused, apprehensive, simply overwhelmed. They do not know who the people are in the court, what the procedures are, what the legal terms used mean. They are unaware of their rights, e.g. to cross-examine the evidence given by the police officer. They simply answer the questions from the prosecutor (that is if they speak at all.) The Child Care Officer is not properly prepared when he is asked if he has any questions.

The parents would not know whom to question. Do they comprehend the importance of questioning at this stage? Little account is taken of the lack of experience of the child and the parents with children's court procedures. Police evidence and testimony is seldom if ever contested. The magistrate rarely questions the arresting officer's testimony. The prosecutor offers details concerning the child's previous offences, if any, place of work, residence, etc. The Child Care Officer has not the time to research the case to make available to the magistrate the background and circumstances to complete the picture of the child before the court.

The magistrate becomes an administrator stamping forms while the typewriter is silent for a while. The magistrate makes his decision."Often you don't know whether the magistrate is sentencing the child who is walking out of the courtroom or the one who has just entered" was one social worker's observation.

Out they all go, parents and child, to see the Child Care Officer and to have some explanations made. How much of the process had meaning for them? Whatever the underlying philosophy of the children's court, procedural justice must be guaranteed for the child.

The President's Commission in America has said "the right to confront one's accusers, to cross examine witnesses, to present evidence and testimony of one's own, to be free of prejudicial and unreliable evidence, to participate meaningfully in the dispositional decision, to take an appeal - all have substantial meaning for the overwhelming majority of persons brought before the juvenile court, only if they are provided with competent lawyers who can invoke these rights effectively".

Legal representation for the child is a rare exception in Queensland, despite publicity given to legal aid provision, and despite the entitlement stated by the magistrate.

Would you face a criminal charge unrepresented? Free legal aid is readily available to adults. What about the children's court? Is it a case of "out of sight and out of mind" for lawyers? Or because its work involves little financial reward, little prestige? Or because its work requires a sensitivity and commitment to children's needs and a recognition of their rights? The child literally has no voice; he cannot speak for himself in any real sense in the courtroom nor can his parents. Many of them do not utter a single word after pleading.

In a courtroom where one would most expect the rights of the child to have high priority, it would seem that the child has very few legal rights. In such a situation, the child might feel justified in considering that the court is set up not to look after his interest, but to reinforce societies rules and sanctions on children.

How could a child who has no real chance to defend himself view the court as anything but a punishing and authoritarian instrument in the hands of adults who supposedly are there to promote his interests?

Who does speak for them and for whose best interests? Who is his advocate? Often we are told it is the magistrate who is seen to be a parental figure for the child, who from his position could influence the child in a positive direction and at the same time be his advocate, his legal representative, to cross examine witnesses on the child's behalf; and still be the person within the legal system to bring down the disposition order. Truly an incredible confusion of roles for the magistrate whose duty and responsibility are not made any easier by his lack of professionalized training in this area.

What of the Child Care Officer's role as advocate? He has no authority to act on behalf of the child in the court process. His lack of legal training hinders his ability to communicate the needs of the child for care and/or treatment to the court. His role in the court is to present a report of the child's

social background and circumstances. His concern begins outside the court or in the waiting room. He has responsibility for a large number of children. Often he has insufficient time to prepare a pre-sentence report as appearance in the court is dependent upon notification given to him by the court. Thus he is often in a situation which he finds frustrating for himself professionally and of little advantage to the child.

Mr. Justice Kirby, opening the Australian Law Convention recently, said that the over population of the legal profession would cause lawyers to go into fields of law of no snob value. It is about time - hopefully, one of them will be child welfare law. Law students are taught law as though children did not exist except as divisible property. (Child welfare - that is not really law, is it? - more sociology!). Social work students are taught no law. An advocate for the child must be a special kind of lawyer who will accept the child as a separate legal party. Solicitors often look upon the parents as their clients when, in fact, their sole responsibility is to the child. To meet this responsibility a solicitor must be:

(a) an investigator whose task it is to seek out all the relevant facts;

(b) a counsel who must ensure firstly that all the facts are before the court at all hearings, and secondly that the court has before it at the dispositional hearing all available options and

(c) a guardian (in the simplest sense of the word), whose task it is to ensure that the child's interests are fully protected.

In calling for free legal representation for persons appearing in the children's court, isn't one simply seeking equal protection of the law for children?

What of the interests of the child after he leaves the court? The magistrate can make the following decisions :-

- admonished and discharged
- fined
- supervision
- care and protection
- care and control

The procedure of referring a child to a welfare agency for counselling is rarely used. The only sources offered are Juvenile Aid and Children's Services - scarcely an availability of viable options.

If a child is placed on one of the care orders, the ultimate decision as to what will happen to him rests with the Director of Children's Services. SS. 58, 65 charge the Director with the duty of utilizing his power, and the resources of the Department, so as to further the best interests of the child in care. Is it possible to further the best interests of the child in care and control with the resources which exist for that purpose in Queensland at present? It can scarcely be said that there is a range of facilities. Kilimna Girls' Home, Westbrook Training Centre and Wilson Youth Hospital - the latter two both large institutions which no matter how good their treatment program for the most part fail to reform and correct. Basic infringements of human rights go on every day in such institutions in the name of expediency and smooth running, e.g. tantrum rooms.

Barton in 1959 outlined some of the reasons for the failure of large institutions:

(a) Too many children in one institution to allow adequate individual treatment.

(b) The admixture of widely different children in a given institution - particularly illustrated in the case of Wilson Youth Hospital, a remand centre, a psychiatric assessment centre, a treatment centre, and as already stated, a children's court venue.

(c) Lack of understanding by staff of the dynamic nature of each child's behaviour.

(d) Too much political domination and interference.

(e) Delinquent children are treated in isolation from the communities to which they are to return.

Current opinion has largely reflected Barton's thinking and has been accompanied by changes in policy throughout the world, whereby large closed institutes have been radically reformed and used as a totally last resort. It would appear that in Queensland, the institutional punishment mentality is difficult to shake off. Children in care have the right to expect appropriate treatment. One could well question whether an institution such as Wilson Youth Hospital has as its aims the successful return of the child to the community. Thus for example, the girls have very few responsibilities, receive no adequate education, job training or sex education. They spend most of their day knitting and crocheting and close relationships between girls and staff are discouraged. Visiting is limited to one hour one day of the weekend - an especially poignant aspect for children from the country. Children put into an institution for an indeterminate sentence have no idea of what is going to happen to them; nor very often

do their parents. We simply do not have sufficient resources for these children in our State. Could it be said that the availability of beds is the deciding factor on what arrangements are made for the child in his best interests?

Many other aspects of the Children's Services Act were considered by the Demack Report; a report of a Commission of Inquiry into the Nature and Extent of the Problems of Youth in Queensland.

Though pertaining more to the situation of the adolescent, recommendations were made by that report in the best interests of the child on the ground that the influence upon a young child's life has considerable bearing upon its behaviour in adolescence. The commission stated that in the area of non-accidental injury to children the interests of the child are paramount. They are indeed. These children are in peril. The commission looked at the matter of reporting such injury to children and recommended that medical practitioners should be able to report to police or the Children's Services Department, and that they be given protection from defamation proceedings. These recommendations are salutary. We are at last facing up to the horror of abuse which everyone is reluctant to accept.

We are doing something - for example, we have a Child Protection Unit. Are we doing enough when that unit is hearing of only a quarter to a third of the cases it should be hearing of on world figures of the syndrome? Who are these children whose lives are at stake? We must identify them. The primary vehicle for identification is the mandatory reporting statute to identify the child in peril as quickly as possible. Some American jurisdictions such as Connecticut, Colorado, Idaho require reporting not only of suspected cases of child abuse but also of circumstances and conditions which might reasonably result in abuse.

Reporting should be mandatory not only in the case of doctors but also other classes of persons in day to day contact with children. For example, teachers in primary and secondary schools who at present see many cases of non-accidental physical injury, neglect, sexual molestation and mental injury. Although they are concerned, they are reluctant to take the matter up with authorities. "What can I do?" they ask. The observer is required to do no more than report - the only requirement is that the person notify the authorities when he has reasonable cause to suspect that the child has been abused.

The observer must believe something good will come of notification, that the health care services can provide immediate and worthwhile help for both parents and child. Notification must go hand in hand with immediate rescue. What is desperately needed is treatment for the parents, the child and the family. Criminal prosecution of the abusing adult may satiate society's needs for retribution but it neither cures the problem nor even addresses the issue of providing for the child's independent interests.

Mandatory reporting has been working successfully in American states for several years. Some States provide for independent representation - a guardian ad litem for the child, in cases where judicial process ensues. Three weeks after the introduction of mandatory reporting in New South Wales last month welfare teams uncovered more cases than they formerly did in six months. This information was in the press in the same week as a report of the Australian and New Zealand Burns Association Annual Conference of the deliberate burning of children with cigarettes, matches, hot pokers and boiling water.

(2) *The Adoption Act* in Queensland, like all other such Acts in the Commonwealth, establishes in Section 10 that the welfare of the child shall be the paramount consideration. In Queensland, the Director of the Department of Children's Services not only exercises sole authority to arrange adoptions; he also makes the adoption orders. For years now we have spoken of adoption as a service for children but although we have stressed the welfare of the child, mostly adoption has been a service for adults - a neat solution to the adult problems of infertility and illegitimacy. Adoption has developed separately from other services to children and has been largely confined to healthy young babies, preferably white, who have been medically examined and pronounced fit for adoption. But now we are at a turning point in the development of adoption services. The Director is no longer deluged with these babies.

As Jane Rowe, Director of the Association of British Adoption and Fostering Agencies, at the First Australian Conference on Adoption in Sydney, 1976, pointed out it is now time for us to consider the development of services for children with very special needs - the child who most needs new parents, the one who is handicapped, the child of minority race, the older unwanted, the disturbed and difficult child - children living in institutions or other temporary care. They have seldom been considered for this form of care - they are children who wait - wait in limbo, never really belonging to anyone except on a temporary and ill-defined or partial basis (Rowe and Lambert, 1973).

Bryce and Ehlert (1971) put their case strongly when they wrote: "They can not invest except in a minimal way (just enough to survive) if tomorrow the relationship may be severed. To grow, the child needs at least the promise of permanency in relationships and some continuity of environment".

Termination of parental rights has been the subject of hot debate in America and Britain for some time. When a parent beats, burns and maims his child, we instantly react by feeling that he is not fit to be a parent. When parents abandon a child and disappear for years, most people would consider they had forfeited the right

to claim the child as theirs. Early in the century no one would have questioned a parent's right to take back a child at anytime he chose. Our new knowledge of child development and the crucial importance of personal relationships to a growing child's emotional health make the parents' wishes and claims seem very much less over-riding (Frend, Goldstein and Solint, 1973). We have also become aware of the crucial importance of time in relation to a child's development. The Jesuits were right when they stressed the first seven years of a child's upbringing as of basic importance to his character and spiritual life. Joe Reid of the Child Welfare League of America put things succinctly when he said: "Children need what they need when they need it. Providing it later is always too late." We cannot put children in cold storage while we argue about what to do with them, or let them sit there waiting, waiting for us to make decisions we are not prepared to face up to.

Watson (1968) says: "...a child must grow up knowing that affection and dependency are reciprocal. For him to value himself as a person, he must know that not only is some adult vital and important to him but that he is important and vital to some adult". Yet many children in care know well that the people looking after them don't much mind whether they come or go. In spite of our increasing awareness of a child's needs for secure, affectionate relationships and security, we still have many children in long term care who have virtually no contact with their natural parents or are unlikely to return to them again. In New York state, child care agencies are called on every two years to show cause why a child has not been moved into a better situation. Under the new Children's Act in Britain, agencies have power to take a child before the court and ask that he be freed for adoption without his parents' consent, or even against their wishes, if there are grounds for this. The grounds are specified and there are a number of safeguards for parents, but it is still a major shift in traditional legal patterns.

The law in Queensland provides for dispensing with the consent of a person to the adoption of a child by the Supreme Court where it is satisfied that -

(a) after reasonable inquiry, that person cannot be found or identified;

(b) that person is in such a physical or mental condition as not to be capable of properly considering the question whether he should give his consent;

(c) that person has abandoned, deserted or persistently neglected or ill-treated the child;

(d) the person has for a period of not less than one year failed without reasonable cause to discharge the obligations of a parent or guardian as the case may be of a child;

(e) there are any other special circumstances by reason of which the consent may properly be dispensed with.

The only person who can apply to the court for such an order from the court is the Director; and we must ask if that is why orders are seldom made? Perhaps the situation would be improved if the person who really cared whether the order was made or not, i.e. the person who wanted to adopt the child, could apply to the court in his own right - who speaks for these children who are without families? (If it is hard for a parent to be childless, how much harder for a child to be parentless.) It hits home to read that Dennis Smith, a 17 year old from San Francisco now in his seventeenth foster home has filed a suit for $500,000 damages from a county social services agency on grounds that he should have been placed for adoption at an early age (Kadushin, 1970).

Why can't foster parents be given this locus standi? Many foster parents who have had a child in their care for years with little or no parental contact want to adopt. Why cannot they apply for dispensation of consent in the circumstances set out under the Act? Many years ago we convinced ourselves that family foster homes would provide the ultimate solution for the child without parents or the child whose parents were dysfunctional.

> "What we did not see was that the solution was not a permanent solution for most of the children entering care. What we pieced together was a system designed to provide safe harbour for children in jeopardy. The system didn't offer the child permanency and that was its fatal flaw. The only system which serves the best interests of the child who waits is adoption."

Thus spoke Kay Donley, Director, Spaulding for Children, Michigan, U.S.A. at the First Australian Adoption Conference.

Jan Rowe says that one of the most exciting developments in social work today is the possibility that adoption offers for providing new families for older children whose original families have failed them. Professor Kadushin and others have demonstrated that adoptions of school age children are remarkably successful especially when compared with their high breakdown rate in foster homes. Indeed specialist agencies in America such as Spaulding for Children have shown us that the term unadoptable is not applicable to the word children at all. The Act says that their interests shall be paramount - perhaps they have been for the healthy, medically fit white new born; what of the children who wait?

(3) Finally, I look briefly at the child in the custody case. Lawyers who have almost ignored children in the juvenile justice system have on the other hand for many years been aware of their existence in matrimonial disputes - aware of them as property which can be quarrelled over and divided up, rather than as persons in

their own right. *The Family Law Act* Section 62 states that "in proceedings with respect to the custody or guardianship of or access to the child of the marriage the court shall regard the welfare of the child as the paramount consideration".

As Judge Demack of the Family Court has said, "The welfare of the child in any particular case must be determined on the facts of the particular case.....In recent years there has been an increasing awareness of the damage done to the emotional development of children if they are suddenly removed from a known secure supporting set of relationships and thrust among strangers even if there be some blood relationship with one or more of the strangers. In some cases this may be explored by the giving of expert testimony, in others the ordinary experience of the court is relied on".

However, in a recent decision by the Full Bench of the Family Court, Evatt, Pawley and Demack commented on the evidence presented by the parties in a custody dispute in the following terms:

> ".....despite the great mass of affidavit and oral evidence there is little information about the child L. now aged 8, who is the central figure in the case."

This statement is a directive to lawyers to present the courts with more comprehensive information, not only dealing with the merits or otherwise of the parents involved in the dispute but also information related to the child. It is difficult to understand why the interests of the child are not put before the court by the child himself through his own representative.

Section 65 of the Act provides for such representation. When in proceedings with respect to the custody guardianship or maintenance of or access to a child of a marriage, it appears to the court, that the child ought to be separately represented, the court may of its own motion or on the application of the child or of organizing council concerned with the welfare of children or of any other person, order that the child be separately represented and the court may take such other orders as it thinks necessary for the purpose of securing such representation.

Regrettably this provision of the Act, which on its introduction was applauded by all concerned with the rights of children, is seldom used. The Goldstein, Frend and Solint work "*Beyond the Best Interest of the Child*" which is becoming influential in the area of custody as it clarifies the concept of the psychological parent and differentiates the role of biological creation of a child and parenting in the sense of nurturing and bringing up, argue that the court cannot do complete justice unless the child is recognised as a necessary, indeed indispensable, party to the proceeding.

It has been argued that the child's welfare, including his psychological needs, are put before the court by the court's family counsellors. It doesn't seem fair that the two parents are represented by experienced lawyers while the child's needs are merely put forward in a counsellor's report? Are these reports sufficient to determine questions such as which relationship is most important to the child? Why are we still hearing of complaints against our legal system emotionally abusing children in custody cases? It is disappointing, surely, that the single legislative recognition in this country of a child's right to independent representation is almost ignored by the courts.

If at law the interests of the child are to be paramount, the child must have a voice, an advocate to speak for him, when he cannot speak for himself, so that for the delinquent child, the neglected child, the abused child, the child who waits - as for all children - the best is yet to be.

References

Bryce, M. and Ehlert, R.144. Foster Children, *Child Welfare*, 1971, Vol. L. No.9, 499-503.

Cairns, Bernard. The Concept of the Children's Court in Tasmania. *Australian Law Journal*, 1975, 49, pp.275-282.

Foreman, Lynne. *Children or Families?* Australian Government Social Welfare Commission, 1975.

Frend, A., Goldstein, T. and Solint, A. *Beyond the Best Interests of the Child.* London: Free Press, 1973.

Kadushin, A. *Adopting older children.* New York : Columbia University Press, 1970.

Rowe, J. and Lambert, L. *Children who wait.* Association of British Adoption Agencies, 1973.

Watson, K. *Long Term Foster Care : Default or Design.* Child Welfare, 1960, XLVII, No.6, 331-338.

Wooden, Kenneth. *Weeping in the Playtime of Others.* New York : McGraw Hill, 1976.

CHAPTER 7

IN LAW, THE INTERESTS OF THE CHILD SHALL BE PARAMOUNT : A VIEWPOINT

Lynne Foreman

Synopsis

In the following talk I have sought to demonstrate two points. Firstly, that the doctrine of parens patriae has been misunderstood and should be viewed within its historical perspective in order to appropriately interpret its present application. Secondly, that the development of children's rights must proceed cautiously as in some instances the rights and obligations of the State, the community and the family intertwine and to ignore these can diminish rather than enhance the notion of 'children's rights'.

Also there is confusion surrounding the paramountcy principle and law reform which it is suggested should be reappraised by adopting an alternative focus when the law is obliged to intervene on behalf of the child.

When the law is required to intervene in matters involving the present and future needs of children, one of the considerations upon which such issues are normally resolved is the so-called doctrine of parens patriae. Originally this term was used to describe the obligation of the sovereign, through his Chancellors, to oversee the welfare of children in the realm.

However, an examination of legal history reveals that this doctrine has changed and been considerably diluted over the centuries. Nowadays, the term is used in a shorthand sort of way, to describe the doctrine that the welfare of the child is the 'paramount' concern of the court in resolving issues which involve children.

Some commentators have become somewhat cynical about the application of this so-called 'welfare approach' and advocate a variety of means by which 'justice' for the child can be strengthened. Views on means of strengthening the legal process range from implementing the so-called 'charters of children's rights', through a continuum, with advocates at the other end of the range insisting upon a strict rule of law approach. The strict rule of law approach is a term which is often used interchangeably with another term, sometimes called the due process approach. For instance, legislation may stipulate what evidentiary procedure or form of legal

representation must be followed. In contrast, the welfare (or parens patriae approach) adopts a somewhat different viewpoint. This approach concentrates on the needs of the child rather than on the protection of his or her legal rights.

Stripped of the rhetoric, which surrounds much of the debate over which approach is preferable, in essence what is of some concern, is that there is a gap between the ideal position of the child in the eyes of the law and the real position which neither the implementation of charters for children's rights or the adoption of a 'pure' welfare approach resolves.

In between, there must be a workable alternative. This must be based on practical, enforceable standards which must have a firm theoretical foundation for such a policy to be effective and efficient. A starting point to examine any workable alternative must be an understanding of the special needs of children. However, the special needs of children cannot, in my opinion, be viewed in isolation from the rights and duties which these impose on others. Nor can any practical alternative be feasible without an appreciation of the historical context, the present administration and the special needs of children within the framework of the legal process. More specifically, we must strive to comprehend what are the needs of children who come into contact with legal processes and how the legal heritage can embrace or encase changing views on these special needs.

Some refer to these special needs as 'children's rights'; however, in my view, the meaning of this term has been obscured. It is in danger of becoming a gimmicky catchphrase which ignores the broader framework of intertwining rights, interests and obligations that involve interaction between the child, the family, the State and other individuals and groups who have not only an interest, but certain obligations and accountability, both to the child and to its family.

All these interests and obligations intertwine: the interests of the child, the duties and practicable rights of children at certain ages, the ideal and real rights of the child, of the family, of the State and of others for instance, who work in the child welfare field. At law the fact that the interests of the child are said to be of paramount concern does not necessarily mean that the child's welfare is the only consideration taken into account by a court determining an issue involving a child. Other considerations are not to be excluded, but are said to be subsumed or subordinated. Many expect the law to regard the interests of the child as the prime and paramount consideration in determining its needs. I suggest that the doctrine of parens patriae is often misunderstood.

Nowadays the resolution of many legal proceedings in which children become involved, such as divorce, custody, adoption, maintenance, neglect and criminal charges is said to be based on this so-called paramountcy principle. But many of the proponents of the 'welfare approach' and 'rule of law approach' fail to recognize that whilst a court will have due regard for the welfare of the child this does not mean that other considerations will be excluded.

Thus a good deal of the contemporary debate surrounding 'children's rights' and reforming the law relating to children is based on rather shaky ground. Firstly, because the paramountcy principle is misapplied, or misunderstood, and secondly because the historical context of the law relating to children is ignored. Quite often, for instance, it is overlooked that children's courts developed to function as non-legal social control agencies providing needed care to endangered children and resorting to coercion only as necessary to serve, what was understood, in that context, as the paramount interest of the child.

Bear in mind that when children's courts were developed they were established to aid impoverished and needy children. Children's courts were not established to cope with so-called 'middle-class' children. The court was originally designed to segregate children from adult courts, it was intended that hearings be conducted informally, that legal technicalities be put aside. It was felt that because the officials of the court were acting as parens patriae any claim that the child needed representation or other protection of his 'rights' was misconceived.

The court process was intended to be paternalistic instead of adversary. The function of the courts was to determine the child's problem and then to prescribe to his needs. It was not really intended to judge his acts and decide his rights. Putting it another way, the court felt it was less necessary to deduce all the facts establishing guilt than to assess the child's character and needs.

In Australia in recent times there has been a growing scepticism and degree of disillusionment with the operation of children's courts and a number of reasons for this can be isolated. Firstly, there is concern that the welfare approach is cloaking the reality of punishment under the rubric of a social agency approach. Secondly, that the social agency approach has been undermined by the inadequacy of back-up facilities. In other words, that a punitive reality exists under the rhetorical guise of a welfare approach.

What has happened is that a hybrid system of juvenile justice has developed. The courts have attempted to balance legal and welfare approaches but not subjected cases before them to the same procedural restraints as the criminal justice system. Nor have adequate support

facilities been developed to justify a welfare approach. The original rehabilitative goals remain, in what has become an uneasy balance between the two approaches.

This is how the system operates and that is what the advocates of 'children's rights' want to change. Yet they ignore the two important factors previously mentioned. Children's courts were never designed to function consistently with the due process approach and the doctrine of parens patriae was never intended to empower courts to determine issues involving children on the basis of their needs being the only concern.

It is appropriate in this context to divert and to question whether we want to adopt a due process approach in the strict sense at all. I have had the privilege recently of spending three months in Canada and the United States and I spent some time in a Californian Juvenile Court. It was an extraordinary physical environment, with the judges in gowns and all sorts of court officials in attendance. Obviously it had a highly structured rule of law approach. The judge remarked to me after a hearing "Well you've seen how we operate... The child and the State have lawyers and there are a host of other officials" and he went on to say, "I hope you can come back next year and see the jury as well". He thinks that is where his court is heading and he was very confident that this would happen.

Do we want that in Children's courts in Australia? I don't think so. Not in all instances in any event. We have got to question whether we want a Children's Court at all. But setting that aside for the moment. Consider the implications of introducing a requirement that all children appearing before the court be legally represented. What are the implications of introducing a blanket requirement that all children should be legally represented? A recent study in the U.S.A. indicated that representation of juveniles by attorneys in the States has increased dramatically since the Gault decision. About 75%, or more, of the serious cases are represented. In contrast in Victoria about 18% of all cases in children's courts are represented and there is always a big question mark, especially in the care and protection and care and control cases as to who is represented. Is it the child or is it the parents?

Increased representation gives rise to increased professionalism by prosecutors however and the American experience is that representation of the defendant seems to outpace representation of the State and the community. So a cost factor also intrudes. Whilst this should not be a deciding factor, the point is that disbalance can arise between representation of the State and the defendant. Whilst this would not be a persuasive argument for not permitting legal representation when there are inequities existing in the court process, advocates of legal representation seem to fail to recognize that the interests of the child have to be balanced against the cost factors, the efficiency of the lawyers who are going to represent them (and

their appreciation of the court structure) and where trained lawyers in this area are to come from.

Lawyers are not trained in the behavioural sciences, social workers are not trained in the law, etc. As I remarked in "Children or Families?" what do we want? Do we want our police trained as social workers and our social workers trained as police? We have got to strike some sort of happy medium in this area. Certainly people have to have an understanding of other systems that operate. But we cannot have people becoming dilettantees, they must have professional skills. An article in the *NSW Legal Aid Journal* by Carolyn Simpson illustrates my remarks. Commenting on the advent of the Legal Aid System in Juvenile Courts in New South Wales, she said "Unfortunately solicitors that come to court are totally ignorant of the extent of the system that the magistrate is exercising". "In fact", she says, "basic knowledge of the criminal law is too often lacking". Ms. Simpson went on to say that far too many solicitors in fact seem to appear on behalf of the parents. I have certainly seen this happen in Victoria. Perhaps this is an argument for the child to be represented independently of the parent as can occur under the Family Law Act. In this article the author further notes that conflicts of interest become apparent. "A solicitor cannot be consistent with his or her duty to act for a child, and ask for a period of committal." It is contrary to a lawyer's role. He will never admit guilt. He will never believe his client is guilty until the court says so. Lawyers will fight as best they can. A further point that she makes is also interesting. "The solicitor appears as part of the authority machine and not as the child's advocate."

Overseas all sorts of different systems have been tried. None of them seemed to counteract that particular allegation. I think that what has happened is that the advocates of legal representation overlook the historical framework of the courts to which I referred before. Within the type of structure that has developed it is inconsistent to increase legal representation in what is intended to be a welfare-orientated system.

Advocates of 'children's rights' I suggest, could more profitably spend their time questioning the appropriateness of children's courts altogether. How many children who appear should appear? A good deal depends on the sorts of diversionary processes which develop. And that does not mean to say that even if you do develop diversionary processes or pre-screening devices you are not labelling or stereotyping children. I urge you strongly to keep them out of the system as far as is possible. Happily in Victoria we have developed a cautioning system which goes part of the way to achieving this goal. In the short term since this new cautioning system has been implemented, only about one in ten children who come to police notice are processed through the court instead of being cautioned; processed not being the most desirable word, but perhaps

the most realistic as there is a degree of 'processing'. But it is expected that the one of ten children who proceeds to court probably needs legal intervention.

Unless you are going to opt for the administrative system (a quasi judicial or para-judicial system), which in my view does seriously undermine the child's rights to have his case and his future decided by a proper court of law, then such a diversionary scheme should be the first resource.

I believe that the advocates of 'children's rights' should become more sensitive to the dichotomy which exists between the due process approach (which I remarked does not fit in very easily with the present structure) and the inadequacies of the welfare approach. The welfare approach, of course, is said to create the most abuses but then surely a due process approach amounting to a criminal trial is as dangerous from the child's point of view as well.

To summarize these thoughts, what we must do is to question whether it is appropriate for all children to appear in court; and whether there are adequate diversionary or screening processes which can be employed to keep them out of court. Let us attempt also to increase our degree of tolerance as well and to question, most importantly, the type of court structure which is appropriate.

"*Children or Families*?" examined child welfare legislation in Australia and explored whether legislation was child or family oriented. A comparison of the legislation made it quite clear to me that legislation focussed on the child, to the exclusion of the parents in many states (with the then exception of South Australia). The focus of the law was on the child in trouble rather than on a family at risk. This is where I see our hope for the future; to restructure our juvenile court system and have a court which encourages, and at times insists on parental involvement in the child's future. This serves the interest of the child. It does not necessarily mean that all your families are going to be intact or interested but I think that most people within a welfare system are very interested in their clients and will do their utmost to motivate parental involvement. I feel confident that we can alter our legislative structure and perhaps make it easier for the administrators to get to the heart of the problem rather than try to 'treat' (whatever that means) the child, already in trouble or attend to the needs of the neglected child in isolation from the family. What do I mean by 'the family'? I look towards your Queensland legislation for a definition and that is what I quoted in "*Children or Families*?". I like using the word 'family' in a broad sense. It does not require a legally sanctioned marriage to form a family unit and it is important in this day and age because most legislation concerning children or families concentrates on what I call a 'dominant cultural preference' or the view that a legally

sanctioned marriage provided the only basis for a family unit as it was reflected 50 years ago or more when the legislation was written and that is the legal essence to what do I mean by the 'family'?

The Queensland legislation quoted in "*Children or Families?*"[1] provides a broad definition which recognizes that a legally sanctioned marriage is not required to form a family unit. The legislation quite frequently reflects the dominant cultural preference operating at earlier times and this is not so realistic at this stage.

Perhaps at this stage I should commence to conclude although we have not got very far in the debate at all. We have just opened out the very many avenues and I concentrated on legal representation purely to indicate the sort of hypocrisy that exists when you try and operate a purely due process approach or a parens patriae approach. You cannot do it in my view. You have got to opt for certain other alternatives.

When children get involved in legal proceedings under the present system, they undoubtedly become the meat in the sandwich. They are caught between the welfare approach and the rigid due process system employed in adult courts with which (and we are indebted to television for this) they are most familiar as a result of the number of hours they spend watching re-enactments of adult court proceedings. I suspect that children think this is what a children's court is going to be like. They do seem disappointed if you ask them their reaction to a children's court after a visit. Perhaps they prefer the ritual and vigour of a court trial. I do not think we ask children often enough what they want.

The consequence of employing one approach to the exclusion of the other leaves the child in limbo. The present welfare approach can undoubtedly produce inequities. The due process approach to the exclusion of all else means that we might just as well abolish juvenile courts and try children in adult courts. What we have got to strive for is greater collaboration between the two models.

I hope, in conclusion, I can briefly indicate to you how this can be achieved and in a very scant outline, the model that I suggest be employed. What I have in mind is a practical solution. What I would like to see is an alleviation of the ways in which the current disbalance exists. We can restructure our system so that there is a balance between the child's needs, the protection of society and a recognition that the present system gives insufficient attention to the balancing of the conflicting rights and obligations to be protected and observed. Children have duties and rights.

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[1] Section 8 Children's Services Act of 1965 provides: "Family". The unit constituted by persons standing in the relationship of parent and child.

Parents have duties and rights. The State has duties and rights. Guardians have duties and rights. All these have to be balanced. You cannot just slice off one aspect and ignore the rest in this sort of area, if we are in the business of protecting the interests of children.

We cannot permit our system to become paternalistic or cynical as has occurred in the States, we must strip the rhetoric from the paramountcy principle and recognize that it is unrealistic to enforce this without due regard to the needs of society and the family unit. It is offensive, in my view, to structure a system in which the child wins to the exclusion of all other considerations, and this is yet another argument with respect to legal representation. Is it appropriate to let a youngster off on a technicality? I used to think so, as a lawyer. Perhaps I have become 'polluted'; now I tend to think that this is not always helpful from the child's point of view. It makes a mockery of justice from their perspective. Interestingly, I think that as children are very adaptive they do not really claim that they have rights. They do not understand this concept or the academic concept of justice at all.

Accordingly, if we consider the child's interests and nothing else, this would give the child a status beyond that afforded to the other elements of society. Now people say that children are in a special position. I do not deny this but at the same time we must balance the interests of everybody else. It does not enhance the rights of the child to give them a status far beyond what is expected of them as adults. And it does not enhance the dignity of childhood either. On the contrary, on that basis, the child loses. It is a question of balance.

Children are basically very honest in my experience, and they are usually prepared to admit guilt. We should be building on that honesty. So again although we seem in recent times to have protected their rights by having the parents present at police interviews, we may also have diluted their rights to be honest as they are less likely to admit guilt when they are guilty, if parents are present.

In conclusion, I advocate a system of justice for the child that recognizes that whilst legal representation may be desirable, in the first instance, we must strive to keep the child out of court by employing a diversionary process. When a court appearance seems inevitable, and this would undoubtedly arise where there is the likelihood of serious recidivism or where the outcome of the case would change the child's status (such as being admitted to care), then the child and its family should appear before a specialized family court which can order separate representation for the child when desirable. Very briefly, this is the model, it goes some of the way towards balancing the welfare and strict rule of law approach as it does not attempt to reconcile the two in the same environment.

Obviously this outline begs many questions, but I have been concerned rather more in this talk with developing an appreciation of the pitfalls of opting for a children's rights approach without recognizing the hazards that this may cause to the State, the family and of utmost importance, the child.

Any attempt to graft a due process approach onto a jurisdiction which has its origins in the doctrine of parens patriae is doomed to failure. Further exacerbating the child's position in a court of law by aiming for what will be an uneasy compromise is not in the interests of the child.

By all means, employ both approaches, but at different points of intervention.

Reference

Foreman, Lynne. *Children or Families?* Australian Government Social Welfare Commission, 1975.

CHAPTER 8

ADEQUACY OF LEGISLATION RELATING TO CHILDREN : A VIEWPOINT

Geoffrey W. Smiley

In presenting a paper on this subject I am aware of the enormity of the task, especially as this is only one of three papers addressed to this topic.

Rather than review legislation I would like to present a personal view of legislation as it affects people - children included. You will note that this paper assumes there are a number of deficiencies in some of our existing legislation. I have been involved in the administration of legislation for nearly 11 years and I would suggest that there are reasons beyond the written acts that account for some of the difficulties that concern us.

I have a conviction that although acts and regulations often have good intentions and provisions, the enactment and administration of these does not fill out the promise of the legislation. This is perhaps not a conscious process by bureaucracies but seems to come from a lack of challenge to established procedures and policies by the community.

My very clear memory of working in government settings is the resistance within these organizations to any outside scrutiny of their operations. The intensity of this resistance is often so great that considerable organisational energy is devoted to preserving the organisation from outside interference and even involvements. One often has a feeling that xenophobia rather than involvement in a democratic system of government is what is most characteristic of the organisation.

The reasons for these attitudes are not the subject of this paper but one can say that this attitude inevitably allows for the development of procedures that can compromise the rights of individuals in order to protect the bureaucracy, especially where these two conflict or are in competition.

In my experience this tendency makes legislation less effective and is given impetus by factors operating within bureaucracies, e.g. empire building or competition between and within government departments; incompetent administrators; political interference, etc. Many factors militate against the effective administration of legislation as drafted by parliaments.

The community's involvement needs to be felt more directly by the bureaucracies administering legislation. This provides a challenge to what is being done but also gives community support for legislation and can provide resources to assist. A case which comes to mind is the involvement of consumer groups in exerting pressure on administrators (and politicians) to provide effective services for their needs. In the child welfare field (for example) there is developing a lobby of foster parents. In child health parents have perhaps been too willing to accept uncritically the low levels of resources available. In education I think parents can question developments in a more assertive way to ensure that their children are being involved in programs that will prepare them for future living.

I have been involved in two major challenges by outside agents of the enactment of legislation; my position at that time being a public servant within the system. One was a challenge to Section 27A of the Mental Health Act as it applied to a particular patient; and the other was a challenge of the Director of Children's Services discretionary powers in a custody dispute.

Both of these challenges brought about reflex defensive responses within the government departments concerned. They did however have the effect also of causing the administrations to look more closely at their operations within these areas and some changes resulted - even if not admitted publicly.

These were isolated cases and generally speaking there is very little challenge of the way existing legislation is being administered. More frequent questioning should occur so that it becomes a normal part of the process of the enactment of legislation. It seems to me that this is healthy and responsible, for it opens the organisation to outside influences and brings about a flexibility to response to changing need, let alone the matter of keeping it accountable to the community.

I would make the plea for more advocacy for children as a way of beginning this process in the area of legislation affecting children. It seems that some of the very significant advances in the U.S.A. in children's rights have resulted from this kind of action.

I hope I am not giving the impression that government departments are obstructionist. This is not usually the case. Often departmental officers know the solutions to difficulties but resources are not available or changes are required in legislation. These factors may not see the light of day if the community does not know what is going on. We must also remember that public servants particularly in the state public service, are not permitted to make public comment or criticism unless they first obtain ministerial approval. Thus they cannot usually give useful negative comment. What I have said about government departments can also apply to voluntary agencies even if to a lesser extent.

The involvement of lawyers in the child welfare, education or health fields seems to me to be part of the solution to providing a scrutiny of legislation. At present there is very little involvement of the legal profession in child welfare. There is also a reluctance within child welfare generally to encourage this involvement. However, the legal process because of the way it operates can expose some of the issues discussed above and this could lead to solutions. It may also lead to changes in legislation.

There are many issues which we must face in child welfare and I would like to see the courts make some decisions in areas such as in certain circumstances dispensing with parental consent to adoption; the rights of children who offend; the responsibility of the community to protect 'at risk' children; the right of children to treatments; the rights of foster parents; services to handicapped children; fathers' rights to family support payments, and so the list could go on.

Legislation should state clearly what rights children and families have in certain circumstances. At present administrative discretion is involved in areas where eligibility should be stated. In other areas there is no effective appeal against administrative decision making. Clearly these are matters which would be faced squarely if challenges from the community resulted in more clear definition of children's rights and community/government responsibilities.

If pressed to state what changes are most necessary in the legislation affecting children I would give two major areas:

(1) the need to define children's rights in each of the legislative circumstances e.g. juvenile offenders; custody disputes; children 'in care'; services to children, etc.

Such vague terms as 'the interests of the child shall be paramount' are not sufficient as there can be no measure of anyone's failure to regard the interests as paramount in any specific decision.

I think that there is a need to define what rights or expectations children can have in law. A clear definition then allows for children and their representatives to know what rights they can exert or call upon.

It also allows for appropriate action to be taken to obtain rights which are not yet provided for in legislation.

(2) the need to also define the process by which the child can take up rights as defined in legislation e.g. (separate representation).

This is a necessary element in any legislation. If rights are defined but there are no provisions for them to be availed of, then the purpose of the legislation is defeated. Resources must be available

to enact legislation. Some of the USA legislation in child's rights have floundered because of insufficient resources to provide the services stated as rights.

These comments of mine are very general in nature because I am really speaking of a general review of legislation as the first prerequisite to any attempts at changes. A basic statement is required.

In conclusion I would again make a call for more involvement of the legal profession in child legislation. This would be in an advocacy sense and would require lawyers who are involved to have special training or expertise in this field. The arrangement would at times involve some tension between the different professions but the overall effect would be to the benefit of children. The social sciences, education, health and the legal profession share concern for social justice and I think the next few years must bring a greater concern for children's rights and a willingness by the community to support these being included in legislation. Let us work together in cooperation to this end.

CHAPTER 9

THE ADEQUACY OF LEGISLATION RELATING TO CHILDREN : A VIEWPOINT

D.A.C. Smith

I welcome the opportunity for this type of forum which brings welfare, education and legal views into an interface situation. Too much we fail to have cross communication and hide our fears and jealousies behind such excuses as wanting to avoid being accused of influencing pleas, or of arranging justice outside the court, or being too busy to communicate other than on the pressing individual cases that constantly face us; or it could be that we in welfare put ourselves down and are unreasonably fearful of lawyers.

There remain large areas where welfare, education and the law should get together in an effort to achieve at least parallel development and approach rather than each of us going ahead on our own individual courses - which in turn leads to misunderstandings and scapegoating.

The Social Welfare Commission publication "*Children or Families?*" by Lynne Foreman, raises this issue of there being little or no collaboration, and asks whether this is due to compartmentalisation of services or perhaps an attitude of territoriality. The author stresses the need for cooperation between welfare, the law, education and the police. It is not my job here to determine why, or even whether, such a situation need exist here. But I agree with the need for such cooperation and express my appreciation to the planners of this seminar for their contribution in bringing together education, the law and welfare in what, hopefully, will prove to be a very helpful forum.

As there are three contributors to this topic, I have confined what I want to say to a few areas which are of concern to me and which are ones which we face regularly. These relate to children "in care", and the "placement" of these children, including issues of custody; and a second major area of juvenile justice and young offenders.

I would like at this point to stress that what I say is a personal opinion and I am speaking here as an individual. My views may not represent those of my Department.

Quentin Bryce has pointed to the inadequacies of legal provisions for children. It is true that few children are legally represented in courts and usually this is only when such representation is arranged by parents and therefore as part of the representation of parents themselves.

Where there is conflict between child and parent, for any separate representation of the child, reliance has to be placed on a "social work" report if such a report is requested by the court.

Often the court would not be aware of the existence of any conflict between child and parents as the child cannot really express himself in a court and in the presence of parents, and it is often information regarding the "interests of the parents" rather than the "interests of the child" that is all that is available to the court.

I sometimes do not know whether it is legislation or practice that needs looking at - so I too need to get together with legal people to help me work that out. However, on this point,it seems to me that legislation may not be very adequate in the area of representation for children in matters of custody, "care" order applications or for young offenders. Perhaps it should be mandatory that either representation or a "social work" report or both be available to the court, particularly in some specified circumstances.

I can recall a case where there was a custody action before the Family Court in another State. A mother was applying for custody after years of separation from her children. The father was not contesting the application. It was only that the children were "in care" that another party even knew about it. It was possible for the children's wishes to be represented to the court through a report, but they did not have separate legal representation and if they had not happened to be "in care" they would not automatically have had even the availability of a report on their behalf.

Our legislation, and certainly our practice often seem to reflect "the best interests of parents" rather than "the best interests of the child". Foreman's book already mentioned is worth reading in this regard, as also is a Free Press publication (London, 1973), *Beyond the Best Interests of the Child* by Goldstein, Freud and Solnit which advocates the concept "the least detrimental alternative" based on a principal of maintaining continuity of relationships for the child rather than the rights of biological parents being the paramount consideration.

My particular comments in relation to young offenders and the juvenile justice system are confined to the areas of :-

representation
status offenders
indeterminate sentencing, and
labelling.

Firstly, though, I would like to refer to the "*Time Magazine*" cover story of 11th July, 1977, titled, "The Youth Crime Plague". If this is an accurate assessment of the American juvenile justice system, then it is frightening. I should say that I feel the report is sensational journalism; it is certainly superficial; and although I cannot comment on the American situation, it is not a reflection of our situation, at least in Queensland.

The report refers to a new breed of child offender who casually commits murder, rape, assault and arson and who engages in mugging for the sake of mugging, without provocation and at an ever-decreasing age. Despite the limitations I have mentioned, the "Time" report does however lend itself for use as an example of principles which should be discussed.

One is the question of whether the juvenile justice and juvenile court system is effective in dealing with serious juvenile offenders. This is a legitimate question, though it should be remembered that most juvenile offending is minor and most juvenile offenders do not re-offend. I should say that, taking into account the points I make in this paper, I believe that the Queensland system as far as the legislation is concerned, and not commenting on resources, can deal with serious juvenile offenders effectively.

The "Time" article refers to the juvenile justice system as "a sieve through which most of these kids come and go with neither punishment nor rehabilitation" (p. 23). It goes on to suggest some questionable "cures", a greater emphasis on punishment and a tougher policy toward violent youths.

The article also raises the issues of serious juvenile offenders going free after getting off in court through failure of witnesses to attend or some legal technicality. This latter point is one to which I wish to refer in relation to the suggestion of legal representation for all juvenile offenders.

Prior to the 1965 Children's Services Act coming into effect, a number of offences committed by children (e.g. breaking and entering) had to go to the District Court for final determination. They are now able to be dealt with in the Children's Court, and usually are. However, because they then had to go to the District Court, we normally advised a child when acting in the absence of his parents, to plead not guilty as legal representation was avilable if committed for trial, but not if committed for sentence.

One boy, I can recall, could not understand why I should advise him to plead not guilty when he knew he was guilty and was prepared to say so. My explanations did not convince him, so I gave consent to his guilty plea.

We must ask ourselves what it does to a child's moral development if, by giving him representation, he is encouraged to plead not guilty and to fight a charge which he knows he is guilty of, and the defence is only on legal technicalities.

My point is not that there should not be universal representation - I believe there should be. The point is that such representation needs to be carefully offered, within the framework of an understanding of child and adolescent development, particularly in the area of moral development.

Maybe the representation should be a joint legal and welfare representation, as either without the other could be detrimental.

Considering the situation of status offenders - sometimes referred to as juvenile victimless crime, e.g. truancy, running away from home, uncontrollability - it is of concern that they are often treated in the same way as other offenders. They are treated in the same court with the same facilities. Their committals are usually for a longer time and they are sometimes in custodial institutions longer.

As part of the review of legislation in New South Wales, Judge A.G. Muir, in his report wrote -

> "During the course of my enquiry at Anglewood where juveniles committed to an institution only in respect of truancy, resented the position that caused them, for the purposes of remedial training, to be held for a decidedly longer period than an offender who had been committed to some other institution for serious offences, but who was released within a period of about four or five months."

I feel we must question the adequacy of any law which allows this to happen, and most children's law in the Australian States does permit this to happen. At least Anglewood (N.S.W.) only had status offenders mixing with other status offenders, not with others who may have committed any offence on the statutes.

To move to a brief discussion of the question of indeterminate sentencing of juveniles - much sentencing of juveniles is indeterminate either partially so, or for serious offences, completely indeterminate. Having dealt with a large number of sentenced juveniles in custodial institutions, it is clear to me that indeterminate sentencing has some negative aspects, and for some it is depressing and harmful. I don't know if adults cope well with the unknown - certainly detained juveniles do not. We have noticed many times how "behaviour" improves once a sentence has become determinate and the end date is known. Only then do some children become accessible to treatment.

Indeterminate sentencing must have a built-in aspect of regular reviews. These reviews are not usually stated in legislation, but are dependent on staff being accountable either to their Departmental policies or their personal ethics. I have no reason at all to doubt that staff normally carry out this function adequately, but the legislation does not require it.

In considering the adequacy of legislation in relation to the indeterminate sentencing of juveniles, perhaps two of the pressing questions are whether reviews should be required by law, and whether determination of sentence at some specific point in time should be provided for by law. (That of course is if it is decided that indeterminate sentencing for juveniles should be retained.)

The final point I wish to deal with in the limited time available, is the question of labelling. The whole juvenile justice system labels. As one example of this I will refer to the procedure of taking of fingerprints and photographs of children by police. My experience is that children feel more like criminals if their prints or photographs have been taken by police and the worry is that this establishes or reinforces them into a criminal identification.

Apparently in some countries and in some situations, the police cannot take prints or photographs of juveniles routinely without an order of a Magistrate. This requires them to prove that such procedure is necessary for identification or for evidence.

A Butterworths publication (Bevan, H.K., *The Law Relating to Children*, 1973) has the following to say on the matter -

> "The taking of fingerprints is such a serious interference with individual liberty that it is surprising that the legislation has not dealt comprehensively with it in relation to children."

In the absence of any legislation on these procedures here, perhaps I could adopt the comment in the publication quoted as relevant comment on this one example of the labelling issue and the question of the adequacy of legislation in this area.

In summary, I would like to say two final things.

The first, I feel the adequacy of the law relating to children should be fully and carefully examined, along with procedures and practices. This should include the questions of separate representations and advocacy. It should include, but by no means be limited to, the areas I have referred to in this brief paper. The examination should be a joint approach by an informed law and a realistic welfare.

The second, it is possible for the law to achieve some progress. It is possible for welfare to achieve something; jointly I feel they can do much better. But the law and welfare are but two specialized sections of the community. It is the community that must accept, support and deal with its children who are separated from one or more of their biological parents. And it is the community that must accept, support, deal with and to some degree tolerate and take responsibility for its young offenders. Without the acceptance of these responsibilities it does not matter how adequate the law might be or how good the welfare services might be or even how well they work together.

References

Bevan, H.K. *The Law Relating to Children*, a Butterworths publication, 1973.

Foreman, Lynne. *Children or Families?* Australian Government Social Welfare Commission.

Goldstein, Freud and Solnit, *Beyond the Best Interests of the Child.* London, Free Press, 1973.

Muir, A.G. *Report to the Minister for Youth and Community Services on Certain Parts of the Child Welfare Act and Related Matters.* N.S.W.

CHAPTER 10

NATURAL AND PHYSICAL TREATMENTS AND DIETARY APPROACHES TO THERAPEUTIC INTERVENTION WITH HANDICAPPED CHILDREN

Winifred C. Apelt and Robert J. Andrews

Introduction

The rationale underlying a number of comparatively recent techniques and programs of treatment for handicapped children is the assumption that improvement in inefficient or defective underlying processes is an essential prerequisite for perceptual and intellectual growth and for academic progress (Senf, 1973).

The theories and treatments described in the first section of this paper refer to a category of neurological and developmental irregularities and associated remedial procedures which focus upon the amelioration of identifiable deficits existing within the child.

The approaches reviewed in the second section of the paper are not educational strategies as such but represent attempts at dietary manipulation on two different dimensions:

1. to circumvent the deleterious physical and intellectual consequences of genetic disorders of a biochemical nature; and

2. to change maladaptive behaviour such as hyperactivity, which inhibits efficient learning and cognitive development.

In the case of hyperactivity, in the absence of diagnosed or presumed brain damage, treatment is based on the assumption of unfavourable interaction between genetically-determined susceptibility and the triggering effects of the ingestion of potentially toxic environmental agents.

Natural and Physical Treatments

A Case Study.

Some thirty years ago the parents of a severely brain-damaged two-year old child with an apparently hopeless prognosis began a desperate and fruitless search for medical reassurance and help.

They made contact with a qualified physiotherapist, dietitian and masseuse, whose own grandchild had been born with a similar problem but who, as a result of her treatment, was experiencing a fairly normal childhood. In the mother's own words (Sunday Mail, November 10, 1974):

> *".....she taught us about proper nutrition, the whole grain, the unpolished rice, the soya bean, the abundant use of fruits and vegetables and their juices, the nuts and olive oil, hydrotherapy and so on. She inspired us with hope and in desperation we grasped at it. What had we to lose in any case? There was no hope elsewhere. So we began, just three of us, on an endless round of treatment and juices and new foods. A lot of hot foments were used. These were given down the spine, on the throat and abdomen.*
>
> *Wonder of wonders, before very long the little body began to show some response. The endless head rolling and humming ceased and he gradually became placid and quiet and the tongue was controlled and stayed in place.*
>
> *Could anyone ever really understand the peace and quiet of a night's rest at last and the joy when the child started to move about in the safety cot which had been his home for so long. His response was so rapid that from not being able to sit up at two years of age, he was walking at three years and leading a fairly normal child's life, but the treatment and diet still continued."*

These hard-won accomplishments provided the basis for further progress. The boy attended a special school from the age of ten to twenty-five, where under expert tutelage he learned to read. Now living in the attached residential, he uses a micrometer to test pulsators for washing machines in the sheltered workshop, and cleans wool for the scientists at CSIRO. He has learned to cook. Leisure pursuits include, in addition to his books, rug making, pottery classes and physical fitness activities.

It is impossible after all these years to pinpoint those aspects of the treatment regime which contributed to the functional improvement exhibited by this handicapped person. It might even be argued that the treatment itself had little impact and that the progress demonstrated was the result of the spontaneous recovery often observed with the lapse of time after traumatic brain injury, especially in young children, or that maturational factors were involved. This case study highlights what has been, and still is, one of the major inadequacies in community provision for the handicapped, namely the dearth of quality care and treatment for the very young handicapped child and systematic co-ordinated parental support services.

It should be stressed, however, that not all substitutes for orthodox medical and educational intervention result in favourable outcomes. It is not very many years ago since a young cerebral palsied child died after prolonged immersion in a manure pit. But before we are too hasty, and too severe in our condemnation of the use of unorthodox and unproven methods by unqualified usurpers, we should consider the desperate plight of anxious, often guilt-ridden parents of young handicapped children when faced with a perhaps overly pessimistic prognosis and inadequate treatment facilities. The following quotation from a physician, Stine, should prove a salutary reminder of the unproven status of certain medical treatments administered to earlier generations of patients:

> "*.....the history of medicine and psychiatry is replete with seemingly effective but ultimately spurious cures attributed to bloodletting, emetics, environmental manipulations, fasting and dietary manipulations.*" (1976, p.643).

A somewhat similar statement could be made about a number of so-called educational 'cures' of more recent origin.

It would seem that a more rigorous approach to the evaluation of the effectiveness of treatment regimes for handicapped children is a long overdue development in the fields of both medicine and education.

Sensori-motor and perceptual-motor training

The Doman-Delacato approach

The most radical and certainly the most controversial of the sensori-motor and perceptual approaches to the remediation of learning problems exhibited by children with neurological handicaps, mental retardation and behaviour disorders is that proposed by Glenn Doman and Carl Delacato at the Institutes for the Achievement of Human Potential in Philadelphia. Their program includes the assessment of the developmental problems of handicapped children and the prescription of treatment regimes based on the theory of neurological organization, which seeks to explain the origin of these disorders.

The enthusiasm and support of the popular media for this approach, and its endorsement by many parents whose handicapped children have participated in the program have not been matched by professional acceptance. Several official statements question the validity of the theory, the assessment procedures and aspects of the treatment programs.

Theoretical basis

The core concept of the theory is that of neurological organization. Delacato (1963) defines neurological organization as:

> *".....that physiologically optimum condition which exists uniquely and most completely in man and is the result of a total uninterrupted ontogenetic neural development. This orderly development progresses vertically through the spinal cord.... This progression is an interdependent continuum, hence if a high level of development is unfunctioning or incomplete....lower levels become operative and dominant.... If a lower level is incomplete all succeeding high levels are affected both in relation to their height in the central nervous system and in relation to the chronology of their development. If man does not follow this scheme he exhibits problems of mobility or communication."*

The theory proposes that ontogeny, or the development of the individual, recapitulates phylogeny, the developmental history of the species. This development proceeds in an orderly anatomical sequence through the cord and medulla, pons, mid-brain and cortex and culminates in cortical hemispheric dominance (Kershner, 1968). According to the theory, the child's development of mobility, vision, audition and language parallels, and is functionally related to, his anatomical progress. Disordered developmental patterns are thus believed to be the result of failure to achieve development at a more primitive level. Treatment procedures consist of theoretically-prescribed developmental sequences of motor and perceptual experiences which are considered to be vital factors in normal child development. The peak of neurological organization is reached with the establishment of cortical dominance, which is claimed to exert significant influence in the following areas:

1. achieving mobility in brain-damaged children;
2. prevention of communication disorders;
3. treating disorders of communication;
4. augmenting intelligence and I.Q.;
5. enhancing man's "normal" development and a number of other universal applications including some related to international social goals (Cohen, Bird and Taft, 1970).

Kershner (1968) has pointed out that since neurological development is assumed to be related to psychomotor development, the theory asserts that neurologicallly handicapped children participating in a program of physical activities should achieve increases in both physical and intellectual proficiency.

Assessment

The Developmental Profile, the major assessment instrument, is a taxonomy of developmental skills and activities, related not only to chronological age but to the hierarchy of levels in the brain and spinal cord. It assesses functions in six areas - mobility, language, manual, visual, auditory and tactile competence. The measurements are in units of neurological age. Comparing this with chronological age, the average rate of neurological growth since birth is determined. Gains in performance are assessed by the same technique.

Treatment Procedures

Underlying the treatment advocated by Doman and Delacato are two basic principles:

1. As specified earlier, the brain is an organic hierarchy consisting of parts or subwholes each of which is under the control of higher parts up to the cortex. The lower levels are the most primitive and the earliest to develop. They assert that because:

   "*.....the central nervous system develops from the lowest level up it is logical that therapeutic programs should attempt to recapitulate as far as possible the early sensory and motor factors which influence the development of the brain during infancy.*" (Doman and Thomas, 1968)

2. Children with neurological dysfunctions may be helped by increasing the intensity, frequency and duration of sensory stimulation.

Consistent with the theory, therapeutic procedures comprise the following:

Patterning or the passive imposition of homolateral and contralateral movement patterns by external manipulation of the head and extremities while the child is in a prone position. This is designed to provide the brain with kinaesthetic, proprioceptive and sensory information.

Crawling and creeping in the prone position and on hands and knees respectively, providing experience of primitive sensory and motor activity patterns.

Somersaulting, and being spun while hanging upside down to heighten awareness of one's position in space.

Brachiating or swinging hand over hand on a long horizontal beam painted the colours of the spectrum. According to Doman and Delacato, this is the "missing

link" in the developmental progression from quadripedal to bipedal mobility.

Sensory stimulation with bright lights and loud noises.

Rebreathing into a mask, on the assumption that increases in carbon dioxide levels dilate cerebral blood vessels and promote healing of brain cells.

Dietary restriction, particularly of fluid intake to reduce intracranial pressure.

The establishment of cortical dominance by suppression of the subdominant eye, hand and foot and the promotion of the dominant side.

Critical evaluation of the theory, assessment and treatment procedures

Thus far, in the interests of clarity, the theory and its practical applications have been presented without any attempt at critical evaluation. From the standpoint of scientific acceptability some of the most cogent criticisms relate to the failure:

1. to validate the Doman-Delacato theoretical postulates and the hypotheses derived from them;

2. to establish the validity of the Assessment Profile; and

3. to supply empirical evidence in support of the efficacy of the treatment procedures.

Andrews (1976) in a recent article concluded that the theory had been judged in some quarters to be based on over-simplified concepts of hemispheric dominance and that the assumption that the disabilities experienced by the majority of cases of mental retardation, learning problems and behaviour disorders are caused by poor neurological organizations does not rest on unequivocal research evidence.

Validation of the theory of neurological organization

Robbins (1966), in an empirical test of the validity of the theory of neurological organization, compared the progress of three second grade classes who experienced three different treatments, the experimental one being based on the Doman-Delacato approach. His findings, summarized below, failed to substantiate some basic tenets of the theory:

1. Creeping was not significantly related to reading.

2. When measured by the California Achievement Tests, mean reading differences between children who were lateralized and those who were not, were not significant.

3. When the ability to creep was controlled there were no significant differences in reading between lateralized and non-lateralised subjects.

4. Compared with the two control groups, the experimental subjects did not significantly increase their reading ability following exposure to the experimental training program.

5. The experimental program did not affect the amount of lateralization in the subjects.

No attempts to validate the theory experimentally have been undertaken by its major advocates, and this omission is the source of much professional criticism and concern.

Validation of the Assessment Profile

A second focus of professional concern resides in the failure to demonstrate that the results yielded by the Developmental Profile are correlated with gains derived from well-recognized scales of developmental growth or of performance in the six areas tested.

Validation of the Treatment Procedures

Even more imperative are doubts concerning the appropriateness and effectiveness of the treatment procedures espoused by Doman-Delacato.

Three influential reviews of the efficacy of the Doman-Delacato treatment have now been published (Robbins and Glass, 1969; Neman, Roos, Menolascino, McCann and Heal, 1973; Hallahan and Cruickshank, 1973), none of which have substantiated the effectiveness of this approach in an unequivocal fashion. Robbins and Glass, for instance, reviewed eleven experimental investigations, using sources of invalidity identified by Campbell and Stanley (1966) as criteria of experimental adequacy. They concluded that these studies were "exemplary for their faults".

Hallahan and Cruickshank, in their analysis of the efficacy of perceptual-motor training in general, added four more studies to their review of the Doman-Delacato approach, including two methodologically sound designs (Robbins, 1966; O'Donnell and Eisenson, 1969). Neither of these studies yielded positive effects for the Doman-Delacato procedures on a range of theoretically appropriate outcomes such as creeping, achievement tests, laterality, visual-motor integration and reading.

Neman et al. (1973) reviewed twenty-four studies of Doman-Delacato programs, twelve of which were reported by Delacato (1963, 1966), all of which were claimed to reveal findings supporting this method. The

methodological flaws of these studies have already been identified by Robbins and Glass. Of the twelve other studies examined, only four reported significant positive findings in favour of the Doman-Delacato procedures. All of the reviewers mentioned above agree that to date little scientific support has been amassed for the sensori-motor training approach.

General criticisms

The other criticisms of the Doman-Delacato procedures focus on aspects such as:

(a) the excessive demands made on parents who act in a therapeutic role in an extremely demanding, sustained, rigid and inflexible regime, which contains the risk of neglect of other family members, and which imposes obligations on volunteer teams of helpers;

(b) the high cost of participation, including transport costs and re-evaluation charges;

(c) from a psychological perspective, more damaging to the parents are the possibilities of failure, reflecting as they do on their dedication and ability to carry the program to a successful conclusion and possibly exacerbating existing parental guilt feelings;

(d) from the point of view of the child, there is concern about the enforced restriction of self-motivated age-appropriate activities and experiences.

That some children do improve after participation in the program has been acknowledged, but a number of authorities have suggested that the operation of coincident factors may be responsible. The recent report by the Therapeutic Methods Sub-Committee of the National Health and Medical Research Council (1977), for instance, recognizes the following beneficial features:

(a) thorough assessment with explanation to parents;

(b) the expression of concern and optimism;

(c) direct parental involvement in the child's progress and improvement in community attitudes through involvement in the program;

(d) the benefit to the child from the amount of emotional and sensory stimulation, with intense physical activity enhancing physical strength, co-ordination and posture;

(e) reduction in hyperactivity due to the energy expended in the program and so on.

This sub-committee claims, however, that these benefits are not unique to Doman-Delacato and should be included in all programs of management for neurologically and intellectually handicapped children.

Less controversial than the Doman-Delacato approach are the theories and training procedures advocated by workers such as Kephart (1960), Getman (1965), Barsch (1965), Frostig (1964) and Ayres (1975), all of whom, to varying degrees, exhibit the influence of the pioneering efforts of Strauss and Werner in the fields of motor and perceptual-motor development (Strauss and Kephart, 1955). While their theoretical emphases and treatment orientations differ, these perceptual-motor theorists all endorse the concept of hierarchical development and organization of the central nervous system. Their training procedures are also based upon recognition of the systematic sequential nature of sensory motor, perceptual and cognitive development, and the contributory, interactional nature of experiential opportunities. Kephart, for example, insists that perceptual-motor problems, while anatomical or physical in nature, are aggravated by lack of opportunity, need, or practice in developing the basic abilities of eye-hand co-ordination, form perception and temporal-spatial translation skills. These basic abilities, he insists, are implicated in the types of achievement demanded by schools.

Somewhat ironically, a number of the treatment procedures advocated by these workers in the field of perceptual-motor training do not differ substantially from some components of the Doman-Delacato method. The major difference appears to reside in the emphasis on the treatment of overt behaviours rather than on affecting changes in the central nervous system itself.

Critique of Studies of Perceptual Training

Despite the widespread clinical enthusiasm and support for perceptual-motor training, rigorous controlled experimentation to evaluate the efficacy of these approaches with different groups of exceptional children, is a comparatively recent phenomenon. Halliahan and Cruickshank have reviewed thirty-one experimental investigations published in major journals between 1965 and 1970. Again using the sources of invalidity specified by Campbell and Stanley, their survey identifies only seven studies which meet criteria of experimental adequacy. These authors conclude that the safest verdict they could reach was that it was premature to draw definitive conclusions about the efficacy of perceptual-motor training. They identified a number of vexing questions and issues which emerged in their analysis of the experimental evidence:

1. The appropriate dependent variable to be used to measure perceptual-motor skills.

2. The adequate length of experimental treatment for research purposes.

3. The question of misuse of the training methods.

4. Lack of definition of many of the research populations treated.

5. The need to differentiate between motor and perceptual-motor training; and lastly

6. The effects of structured school programs on the experimental results.

Hallahan and Cruickshank nevertheless stress that it is important not to discard perceptual-motor development theories and training procedures because of the small number of adequate studies by which an evaluation of their effectiveness could be made. Given exemplary studies and adequate treatment time, useful results may become available.

Dietary approaches

The use of dietary manipulation in "diseases whose patho-physiological mechanisms are triggered by dietary components, such as phenylketonuria and reactive ideopathic hypoglycemia" (Stine, 1976: p.643) is now standard practice in the management of these conditions. From a medical perspective, residual issues, in the case of PKU for instance, are related to the optimum levels of phenylalanine in the restricted diet and the optimum time for its discontinuance. It should be emphasized, however, that more complex psychological and behavioural issues still require detailed investigation (Robinson and Robinson, 1976).

Brinkworth (1973(a), 1973(b)), in his program for early intervention with Down's syndrome children, which he claims is directed towards ensuring that these children do not lose in their early development the potential with which they were born, has included dietary components as part of his total approach. The rationale for his treatment procedures is based on the need to compensate for or stimulate the inadequate nervous system, circulation, respiration and digestion of the Down's syndrome infant.

Briefly summarized, the components of Brinkworth's approach consist of:

"1. *Insistence on a low fat, low carbohydrate, high protein diet with vitamin supplements, and the substitution of glucose for other sugars, to provide energy and food for the nervous system by a simpler metabolic pathway, and to avoid obesity.*

2. *Special exercises, first passive and then increasingly active based principally on the muscle stretch and tendon reflexes, to keep the brain well stimulated by proprioceptive and kinaesthetic impulses, which a motionless and hypotonic child could not readily obtain for itself.*

3. *Strong visual, auditory and tactile experience (loud and contrasting sounds, bright light and strongly contrasting colour, and much experience in handling various shapes and textures and in adapting the hand to various shapes were provided).*

4. *Movement in space, and changes in environment (rocking, swinging, rowing and other exercises) to improve balance and proprioception.*

5. *Maternal handling and affection.*

6. *Social life and contact with others.*

7. *Opportunity to benefit from the postural changes available to the normal infant.*

8. *Provision of aids to independent mobility at the appropriate stage.* "

Originally developed to treat Brinkworth's own Down's syndrome daughter, this early intervention program was tested empirically using groups of five experimental infants and twelve controls. While the experimental group showed significant superiority in a number of developmental areas after six months, unfortunately this superiority was eroded when the treatment was terminated. Six months later the differences between the two groups only slightly favoured the experimental group.

This disappointing conclusion is probably related, at least in part, to the paucity of resources invested in the intervention project (Clarke and Clarke, 1973). There is sufficient evidence to suggest the possibility of more favourable outcomes if a more sustained, longitudinal treatment were to be implemented.

The Feingold diet

The Feingold hypothesis that the hyperactivity syndrome is due to genetically determined hypersensitivity of the central nervous system to minute amounts of certain chemical compounds has led to the most widely publicized and publicly acclaimed attempt at dietary manipulation in the associated fields of medicine and education. The

Kaiser-Permanente (K-P.) diet eliminates the hypothesized triggering compounds which include:

1. coal-tar derivatives widely used as artificial food colouring;

2. a large number of synthetic compounds used as food flavouring;

3. naturally occurring compounds containing a salicylate radical which are found in a wide variety of fruits and vegetables; and

4. more recently, Feingold has added some unspecified preservatives to this formidable list (Feingold, 1975).

Stine (1976), in a conceptual analysis of the problems associated with Feingold's hypothesis, stresses that the beneficial effects of dietary manipulation of the disease entities referred to earlier could indicate that a similar mechanism may be operative in hyperactivity. He further points out that:

> *"A second conceptual problem is the proposition that minute amounts of an ingested compound.... could be responsible for major alterations in human behaviour, especially since they must transverse a complicated anatomical and physiological route before reaching their proposed site of action."* (p.643).

This possibility is enhanced, in Stine's view, by the documentation of the potent effects on behaviour of the naturally occurring and synthetic hallucinogens.

Third, Stine claims that his anecdotal studies highlight the need to eliminate the influence of placebo effects and of uncontrolled and unknown variables that might influence reported clinical improvement.

For physicians, parents and teachers of hyperactive children the most compelling question remains - does the diet work?

Spring and Sandoval (1976) have recently published a critical evaluation of the evidence concerning the effectiveness of the K-P diet in treating hyperkinesis. These authors point out that the initial reports of the success of the diet were based on clinical trials and on findings from a number of uncontrolled studies in which the diet was prescribed for groups of disturbed children. On the basis of the data derived from these clinical efforts, Feingold claimed that 50% of the children showed a full response, while 75% improved sufficiently to permit dietary displacement of drug therapy. He has since provided a

more conservative figure of 30% to 50% favourable response. Feingold (1976) has also reported that behavioural change, due to the diet, is followed by marked improvement in scholastic achievement. More specifically he contends that hyperactivity, aggression and impulsiveness are reduced in the initial stages of treatment, followed by improved motor co-ordination evidenced by improved writing and drawing, improved speech and loss of clumsiness. Disturbances of perception and cognition are ameliorated in the final stage of treatment, especially in the case of younger children.

Spring and Sandoval query the legitimacy of these specific claims on a number of grounds:

1. the paucity of the evidence;

2. the global nature of Feingold's clinical measures which preclude evaluation of the parameters of the children's original disorders and of the improvement attributed to the diet (Nutrition Foundation, 1975);

3. failure to specify the methods used to assess such variables as attention span, perception, cognition and scholastic achievement;

4. failure to control for placebo effects.

Spring and Sandoval fear that the last named may be especially suspect as a component of the response to the K-P diet. They cite, for instance, psychological readiness to approve the diet due to the ecology movement, parental preference for certain explanations of a child's disturbed behaviour, and the effort entailed by the mothers in following the diet. Furthermore the child himself might become the locus of a placebo response, since the diet creates strong social demands for a child to modify his behaviour.

Two controlled studies have now been reported in the literature, the first at the University of Pittsburgh (Conners, Goyette, Southwick, Lees and Andrulonis, 1976) and the second at the University of Wisconsin (Harley, Ray, Matthews, Cleeland Tomasi, Eichman and Chun, 1976) for which only a preliminary report is currently available. Both studies employed a double blind cross-over design. Children were selected on the basis of objective criteria of hyperactivity and behavioural data collected during a baseline period. Half the children selected at random were then placed on the K-P diet for several weeks, then switched to a control diet for a similar period. For the remainder of the children the order of the diets was reversed. The control diets did not eliminate artificial flavours and colours but attempts were made to present them as plausible treatments for hyperactivity. The research design thus attempted to minimize the possibility of parental and teacher knowledge of whether a child was on

the experimental or control diet. The clinical investigators were, of course, unaware as to which diet was being administered to the child.

The relative effectiveness of the diets was determined by comparing behavioural data during periods when children were on the two diets, with each child serving as his own control. It should be noted, however, that placebo effects were not necessarily controlled in the case of mothers, who, because of widespread publicity, were probably able to identify the K-P diet.

In the Pittsburgh experiment, fifteen hyperactive school-age children, both boys and girls, were studied. Hyperactive behaviour was rated during the baseline and each of the diet periods by both parents and teachers using a rating scale developed by Conners. Conners combined interview data with these scales to derive a Clinical Global Impression Score. Statistical analysis favoured the K-P diet over the control diet for teacher, but not for parent ratings. The CGI score indicated that only one child showed marked and four moderate improvement on the K-P diet, with one child exhibiting moderate improvement on the control diet, leaving a net score of three with moderate improvement. Thus 27% of the sample improved under the K-P regime, leading Conners to tentatively suggest that there may be a small sub-group of hyperactive children who respond with improved behaviour to the K-P diet. Caution is needed, however, because of small sample size, inconsistent results and the possibility of placebo effects.

In the Wisconsin study, Harley et al. used a sample of thirty-six school-age and ten pre-school age hyperactive boys. In addition to the rating procedures used in the Pittsburgh study, observations of classroom behaviours for the school-age boys were made by trained observers. Tests of attention and perceptual-motor performance were administered at the end of baseline and diet periods. This appears to be the first attempt to objectively verify that disturbances of attention and motor co-ordination are improved by the K-P diet, and these data, when analyzed, will make a critical contribution to evaluation of the efficacy of the K-P diet.

Preliminary analyses indicate that 27% of the school-age boys responded favourably, according to parent ratings, but a significant diet effect was not anticipated for this group. No effect on school behaviours for the K-P diet was found. Teachers rated more boys as improved on the control diet. Classroom observations did not support a significant improvement on the diet and there was little congruence between teacher and parent ratings. On the other hand, the pre-school boys exhibited a greater response to the K-P diet as indicated by parent ratings. Possible explanations for this finding include an age-specific diet effect, fewer diet infractions or the likelihood of a placebo response.

The data presented to date do not offer strong support for the efficacy of the K-P diet. However, both of the investigations have identified a small sub-group of hyperactive children who may have shown a favourable response to the diet. In the light of this possibility, further investigations which introduce a challenge procedure have been proposed.

Because of the tentative nature of the evidence to date, Spring and Sandoval have recommended a moratorium on further public advocacy of the Feingold treatment, primarily because widespread publicity increases the possibility of a placebo response when in fact, food additives may not be aetiologically significant. Also negative consequences may result from the associated risk of delaying or denying appropriate alternative treatment.

Stine, reporting two carefully documented case studies of young hyperactive pre-school boys, one with severe cognitive and the other with emotional problems, treated as a last resort with the Kaiser-Permanente elimination diet, concluded that the diet seemed to play a major role in the alleviation of certain target symptoms of hyperactivity, especially motoric over-activity and extreme impulsiveness. Recognizing that these anecdotal studies are not a substitute for controlled research, he argues the need for careful experimental validation of Feingold's hypothesis.

Stine suggests that, in the interim, therapeutic trials of this treatment modality could be attempted in carefully selected cases. He lists the advantages of this method as:

1. absolute safety from side effects, even granting the low frequency and severity of side-effects of the stimulant drugs,

2. its possible special efficacy with pre-school populations of hyperactive children who, by and large show poor response to medication, and who have not yet been exposed to insistent advertising and peer pressures to ingest artificially coloured and flavoured foods.

3. greater acceptability to parents of young children who exhibit resistance to drug treatment for their youngsters.

Problems

Despite these advantages, several problems in dietary treatment must be acknowledged:

(a) Successful dietary restriction involves major effort by parents to learn and adapt to new techniques of shopping, cooking, budgeting and meal planning.

(b) Older children may indulge in dietary infractions despite the dedication and resolution of parents.

(c) The complexity of the parameters of hyperactive symptomatology; this is illustrated by Stine's concluding paragraph:

> *"The clinical course of both patients was characterized by low and gradual amelioration of target symptoms, in contrast to the sudden dramatic improvements described by Feingold with this method and by Wender and others using Ritalin and Dextroamphetamine. This may be because both patients had other, very severe cognitive or emotional problems that significantly impaired their ability to learn new behaviours and coping techniques."* (p.644)

Comment

An insistent theme in this review and appraisal of some contemporary developments in the management of exceptional children is the dearth of consistent research findings substantiating their effectiveness. The whole question of whether it is ethically and scientifically acceptable to advocate and apply these treatment procedures in the absence of such scientific support appears to hinge on the issue of whether there are potentially harmful elements in the application of the treatment programs. This risk has two dimensions:

1. the introduction of elements which may have direct deleterious consequences for the child, and

2. the maintenance of programs which, while not harmful in themselves, are ineffective in meeting the child's needs and which may discourage the search for a more appropriate alternative.

This constitutes one of the major unresolved dilemmas in the field of special education. Compelling scientific evidence sometimes takes years to obtain; meanwhile, the handicapped child and his parents need help today.

References

Andrews, R.J. The Doman-Delacato program review and comment. *The Exceptional Child* (1976), 23(1) : 61-69.

Ayres, A.J. Sensori-motor foundations of academic ability. In W.M. Cruickshank and D.P. Hallahan (eds.) *Perceptual and learning disabilities in children.* Vol.2: Research and Theory. Syracuse, N.Y., Syracuse Univ. Press, 1975.

Barsch, R. *A movigenic curriculum.* Madison Wisconsin : Wisconsin State Department of Public Instruction, 1965.

Brinkworth, R. Early training for the infant with Down's syndrome (Mongolism). Down's Babies' Association, 1973.

Brinkworth, R. The unfinished child. Effects of early home training on the mongol infant. In Clarke, A.D.B. and Clarke, A.M. (eds.). *Mental retardation and behavioural research.* Churchill Livingstone, London, 1973 : 213-238.

Campbell, D.T. and Stanley, J.C. *Experimental and quasi-experimental designs for research.* Chicago : Rand McNally, 1966.

Clarke, A.D.B. and Clarke, A.M. (eds.). *Mental retardation and behavioural research.* Churchill Livingstone, London, 1973 : 213-238.

Cohen, H.J., Birch, H.G., and Taft, L.T. Some considerations for evaluating the Doman-Delacato patterning method. *Pediatrics,* 1970, 45(2), 302-314.

Conners, C.K., Goyette, C.M., Southwick, D.A., Lees, I.M., and Andrulonis, P.A. Food additives and hyperkinesis : a controlled double-blind study. *Pediatrics,* 1976, 58(2), 154-166.

Delacato, C.H. *The diagnosis and treatment of speech and reading problems.* Springfield. Ill. Charles C. Thomas, 1963.

Delacato, C.H. (ed.) *Neurological organization and reading.* Springfield, Ill. Charles C. Thomas, 1966.

Doman, R.J., and Thomas, E.W. Brain injury as a diagnosis and the results of treatment in 335 brain-injured children. *Human Potential,* 1968, 1(5) : 339-344.

Doman-Delacato Techniques Verdict of NHMRC. *The Medical Journal of Australia.* March, 1977, pp. 354-55.

Feingold, B.F. *Why your child is hyperactive.* N.Y. Random House, 1975.

Feingold, B.F. Hyperkinesis and learning disabilities linked to the ingestion of artificial food colors and flavors. *Journal of Learning Disabilities,* 1976, 9(8), 551-59.

Frostig, Marianne and Horne, W. *The Frostig Program for the development of visual perception.* Chicago, Follett, 1964.

Getman, G.H. The visuo-motor complex in the acquisition of learning skills in Straub, B. and Hellmuth, J. (eds.) *Learning Disorders*. Vol.1, Seattle, Washington : Special Child Publications, 1965.

Hallahan, D.P. and Cruickshank, W.M. *Psycho-educational foundations of learning disabilities*. Englewood Cliffs, New Jersey Prentice Hall, 1973.

Harley, J.P., Ray, R., Matthews, C.G., Clelland, C.S., Tomasi, L., Eichman, P., and Chun, R. Food additives and hyperactivity in children. Unpublished interim summary.

Kephart, N.C. *The slow learner in the classroom*. Columbus, Ohio, Charles E. Merritt, 1960.

Kershner, J.R. Doman-Delacato's theory of neurological organization applied with retarded children. *Exceptional Children* (1968) Feb. 34(6) : 441-450.

Neman, R., Roos, P., McCann, B.M., Menolascino, F.J., and Heal, L.W. Experimental evaluation of sensori-motor patterning used with mentally retarded children. Am. J. of Men. Def. 79(4), 372-384.

O'Donnell, P.A. and Eisenson, J. Delacato training for reading achievement and visual-motor integration. *Journal of Learning Disabilities*, 1969(2), 441-46.

Robbins, M.P. A study of the validity of Delacato's theory of neurological organisation. *Exceptional Children* (1966), April, 517-523.

Robbins, M., and Glass, G.V. The Doman-Delacato rationale : A critical analysis. In J. Hellmuth (ed.)., *Educational therapy*. Vol. II. Seattle: Special Child Publications, 1969.

Robinson, N.M. and Robinson, H.B. *The mentally retarded child* (second edition). New York, McGraw Hill, 1976.

Senf, G.M. Learning disabilities. *Pediatric Clinics of North America* 20(3), August, 1973, pp. 629, 630, 637.

Spring, C., and Sandoval, J. Food additives and hyperkinesis : a critical evaluation of the evidence. *J. Learning Disab.* (1976), 9(9): 560-569.

Stine, J.J. Symptom alleviation in the hyperactive child by dietary modification : A report of two cases. *Am. J. Orthopsychiatry* (1976), 46(4) : 639-645.

Strauss, A.A., and Kephart, N. *Psychopathology and education of the brain-injured child*. Vol. II New York, Grune and Stratton, 1955.

CHAPTER 11

THE NEUROLOGICAL BASIS OF HANDICAPPING CONDITIONS

D.B. Appleton

The brain is a very complex computer system able to accumulate information, store it, and reproduce or utilise that information when required. Problems arise if there is some disturbance in energy supply, energy output or structure. Functionally these can be expressed as biochemical malfunctions, electrical disturbances and structural abnormalities either developmental or acquired respectively.

For normal brain development a suitable environment for the multiplication of the primitive nerve cells is required. Abnormality in nutrition supplied by the placenta or infectious insults or toxic substances may all adversely affect this development. Insults sustained early in gestation may seriously arrest development with consequent gross malformations (Dodge et al. 1975).

The pattern of abnormality will often reflect the stage of gestation at which damage occurs and this is well illustrated by the variable patterns of rubella embryopathy (Stern and Crome, 1972). Prematurity and dysmaturity render the brain more susceptible to damage often with associated hypoxia, hypoglycaemia, or toxaemia.

All too often the cause of significant brain malfunction remains unknown despite intensive investigation. Mabry et al. (1963) were the first to elucidate the problem in some of these with the demonstration of maternal phenylketonuria and the effect of that unusual environment on the developing brain. The precise effects of maternal malnutrition on the developing brain are uncertain.

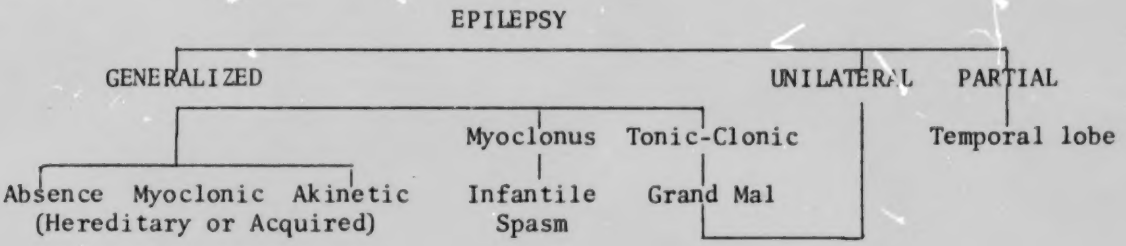
Biochemical disturbances after birth produce a proportion of infants with significant brain disease. These may be disturbances of amino acid, e.g. phenylketonuria, lipid, e.g. Tay-Sachs Disease or carbohydrate e.g. glycogen storage disease. Some are progressive and at present untreatable while others such as phenylketonuria can be arrested (Knox, 1960). There is some evidence also that behaviour of these children is adversely affected also by increasing levels of phenylalamine (Frankenburg et al. 1973).

More recently, much publicity has been given to the effect of chemical toxins on brain function by Feingold (1974). Suffice it to say that, at present, his contentions remain unproven and personal experience has not been convincing.

Biochemical abnormalities are closely related to the second important group of problems to be discussed - the electrical abnormalities which may produce both intellectual and physical handicap. Similarly,

underlying structural disturbance such as porencephaly, or agyria or polymicrogyria may give rise to disturbance of electrical rhythm. Classification of epilepsies, the physical manifestation of the underlying electrical disturbance is difficult, but important since this may indicate the best mode of treatment.

TABLE : Based on Gastaut (1970).



The appropriate therapeutic agents can be then chosen with the knowledge that some epilepsies are extremely difficult to treat e.g. myoclonic and atypical absence types. So frequent at times are the discharges in the atypical absence attacks that the child may be out of contact for much of the time, with each episode lasting seconds only. It is then the frequency which determines the functional disability. Occasionally one sees children with akinetic seizures occurring so frequently that the child is unable to stand or even sit without considerable risk or injury which follows the very rapid loss of tone.

Behavioural disturbance may result from a combination of psychological and epileptic factors (Sutherland, 1969). There may be episodes of impulsive behaviour with or without amnesia for the episode or paroxysms of bad behaviour on a background of generally bad behaviour, sometimes exacerbated by the medications used to control the epilepsy. The abnormality shown on the electroencephalogram in these patients is often in the posterior temporal region.

Many of the drugs used in the treatment of epilepsy may considerably impair learning and behaviour. Dilantin in toxic doses will produce ataxia and there are conflicting reports regarding its effect on learning. Clonazepam is a recently released benzodiazepine derivative effective in some patients with myoclonic seizures and it may produce drowsiness, ataxia and sometimes aggressive personality change (Edwards and Eadie, 1973). Phenobarbitone often induces hyperactivity and is reported by some to have an adverse effect on perceptual-motor behaviour and sustained attention (Hutt et al. 1968) while others report it does not interfere with learning (Wapner et al. 1962). It is probably reasonable to state that all sedative anticonvulsant agents are capable of adversely affecting cognitive development in children.

Finally, some consideration must be given to the effects of structural disturbance in the brain. As mentioned earlier this may result from infective or toxic insults at critical stages of development. It may result from trauma, infection or vascular derangement after birth and at times is intimately linked with other generalised diseases such as Van Recklinghausen's Disease (neurofibromatosis) and tuberous sclerosis.

Perhaps the commonest cause of neurological deficit is a hypoxicischaemic injury which produces non-progressive damage. For example, there are various combinations of clinical signs ranging from minimal cerebral dysfunction to severe retardation, spasticity, choreoathetosis, ataxia, changes in tone, visual and auditory impairment. Postnatally, hypoxia may result from recurrent apnoeic spells or severe respiratory disease particularly in the premature infant. Decreased brain perfusion results from vascular collapse associated with sepsis, or severe brachycardia or cardiac standstill associated with apnoea.

Cortical necrosis and status marmoratus (marble-like changes) of basal ganglia and thalamus are more often associated with hyponaemia while ischaemia more often causes watershed infarcts or periventricular leukomalacia (Volpe, 1974).

The clinical features of cortical necrosis are retardation, seizures and spasticity from cerebral damage and ataxia if the cerebellar cells are affected. Basal ganglia dysfunction in the form of athetosis results from stasis in the deep draining veins or from kernicterus (often with associated deafness). With the improved management and prevention of Rhesus incompatability, the incidence of the latter type has diminished dramatically.

Watershed infarction produces motor deficit particularly in proximal muscle groups and deficits in higher cortical function. The establishment of function in various sites in the brain was recently reviewed by Benton (1977) and much new knowledge was gained by the study of ballistic injuries in two world wars.

Periventricular leucomalacia is common in premature infants and since the lesion is deep near the descending corticospinal fibres from the leg area of cortex, spastic diplegia is the usual result.

Degenerative diseases may be heralded by seizures and loss of cognitive function if grey matter is predominantly involved while change in body tone e.g. spasticity is more likely with white matter diseases. These conditions are quite rare and most distressing to handle.

The neural mechanisms underlying movement, perception and higher order dysfunctions such as apraxia, agnosia and aphasia have traditionally been handled by philosophers and psychologists. No firmly based neurophysiological explanation is yet available for these disorders.

Destructive brain lesions large enough or located precisely enough to cause loss of a previously learned skill produce dementia or significant motor paresis.

Clumsiness will often cause parents and teachers considerable concern. Illingworth (1968) defines this as an older child who is awkward in his movements, like a much younger child. Many possible causes exist and here a normal variation, delayed maturation, familial factors, mental subnormality, minimal cerebral palsy, emotional problems, hyperactivity may need to be considered. No easily definable structural abnormality is evident where death has occurred for other reasons.

Similarly, pathological correlates of children with minimal brain dysfunction and developmental hyperactivity are not available (Werry, 1968). Obviously the important need is to establish that no progressive or treatable disease is present and then provide the necessary medical, behavioural, educational and environmental support.

Management of the child with neurologic disability is difficult and due attention must be made to social and educational problems as well as physical ones. Assessment of treatment is difficult and for this reason many popular programmes have been devised, not the least of which is that popularised by Doman and Delacato. Bax and MacKeith (1967) and Cohen et al. (1970) have reviewed this problem. Particular attention must be given to drug therapy to be certain that toxicity does not develop, further impairing function. Only by a concerted attack involving the cooperation of clinicians, therapists and educationalists with support from interested parents can appropriate progress be made. There is no place for the prima donna. The team approach is all important.

References

Bax, M., and MacKeith, R. The results of treatment. *Develop. Med. Child Neurol.*, 1967, 9, 1.

Benton, A.L. Historical notes of hemispheric dominance. *Arch. Neurol.* 1977, 34, 127.

Cohen, H.J., Birch, H.G. and Taft, L.T. Some considerations for evaluating the Doman-Delacato 'patterning' method. *Pediatrics*, 1970, 45, 302.

Dodge, P.R., Prensky, A.L., and Feigin, R.D. *Nutrition and the developing nervous system*, St. Louis, C.V. Mosby Co., 1975.

Edwards, V.E., and Eadie, M.J. Clonazepam - a clinical study of its effectiveness as an anticonvulsant. *Proc. Aust. Assn. Neurol.*, 1973, 10, 61.

Feingold, B.F. *Why your child is hyperactive.* New York, Random House, 1974.

Frankenburg, W.F., Goldstein, A.D., and Olson, G.O. Behavioural consequences of increased phenylalanine intake by phenylketonuric children: a pilot study describing a methodology. *Amer. J. Ment.-Defic.*, 1973, 77, 524.

Gastaut, H. Clinical and electroencephalographic classification of epileptic seizures. *Epilepsia*, 1970, 11, 102.

Hutt, S.J., Jackson, P.M., Belsham, A., and Higgins, G. Perceptual motor behaviour in relation to blood phenobarbitone level : a preliminary report. *Dev. Med. & Child Neurol.*, 1968, 10, 626.

Illingworth, R.S. Delayed Motor Development. *Ped. Clinics N. Amer.* 1968, 15, 569.

Knox, W.E. An evaluation of the treatment of phenylketonuria with diets low in phenylalanine. *Pediatrics*, 1960, 26, 1.

Mabry, C.C., Denniston, J.C., Nelson, T.L. and Son, C.D. Maternal phenylketonuria - a cause of mental retardation in children without metabolic defect. *N. Eng. J. Med.*, 1963, 269, 1404.

Stern, J., and Crome, L. *Pathology of Mental Retardation.* Edin and London, Churchill Livingstone, 1972.

Sutherland, J.M., and Tait, H. *The Epilepsies*, Edin. and London, E. & S. Livingstone, 1969.

Volpe, J. Neurological disorders of the neonatal period. In S.G. Eliasson, A.L. Prensky, and W.B. Hardin (eds.), *Neurological Pathophysiology*, New York, Oxford Univ. Press, 1974.

Wapner, I., Thurston, D.L., and Holowach, J. Phenobarbital - its effect on learning in epileptic children, *Jn. Aust. Med. Assoc.* 1962, 182, 139.

Werry, J.S. Developmental hyperactivity. *Ped. Clinics N. Amer.*, 1968, 15, 581.

CHAPTER 12

MOTOR SKILLS : THE HUNGARIAN PEDAGOGICAL METHOD FOR TRAINING NEUROLOGICALLY IMPAIRED CHILDREN

Simon Haskell

This paper attempts to describe the development of motor skills in young children. An examination of the features of skilled performance is undertaken, and the implications for neuromuscular functioning in cerebral palsied children considered. The paper goes on to describe a pedagogical approach, devised in Budapest to train brain damaged and motor disordered children.

Physical motor development in children and its relationship to learning is a substantial topic. Therefore, only some of the salient aspects of motor skill development as a background to an understanding of movement disorder in cerebral palsied children are noted. Children suffering from cerebral palsy (CP) are chosen because they exemplify the problems of motor disordered children in a dramatic way.

Until recently psychologists have shown only a limited concern in motor skill development as compared with the usual subjects of interest such as perception, memory, language, etc. This imbalance is being corrected in recent years. A major difficulty facing psychologists studying motor performance, is that of adopting an appropriate strategy towards an understanding and study of motor skill development and its relationship to higher order skills within a hierarchical scheme.

There is little certain knowledge of the temporal organization or the principal parameters along which motor skill development occurs. Skilled performance demands the availability of a complex response system, in "advance of an occurrence in the environment such that the outcome of the response will be quite precisely contingent upon the occurrence of the event". It involves the recognition that such an event will occur, the selection of an appropriate response for execution and effective monitoring of performance by a subject.

In other words, motor functioning outcomes depend upon a number of discrete factors, which include intellectual ability, visuo-motor skill, neuromuscular status, and the availability of appropriate learning opportunities.

Little is known of the developmental changes in skilled motor performance (Haskell et al. 1977). Part of the difficulty in studying these changes is due to the lack of reliable and valid instruments to measure the sequential operations of movement changes in subjects and their identifications and evaluation in a hierarchical scheme.

Basically two viewpoints on motor development exist : descriptive and operational.

Descriptive

The descriptive approach to an understanding of motor development is well known to readers. In the main a taxonomy of the component aspects of motor behaviour is undertaken.

Such studies are confined to an examination and record of the onset of significant manifestations of gross and fine motor behaviour. These are characterised by a progression from simpler to more complex behaviours. Thus sucking reactions, palmar grasp and eye blink yield to more meaningful systems of increasing complexity. The ability to engage in skilled games requires not only precision, speed, accuracy and skilful manipulation but such higher order cognitive skills as complex symbolisation, conceptualisation, language and other abilities to direct motor acts.

Workers with CP and physically handicapped children are showing a greater interest in the strategies employed by these children engaged in skilled manipulative performance. More importantly, some educators seek to translate ideas gained from the developmental theories of Piaget and Gessell into educational programmes.

In essence the Gessell hypothesis views development as a function of maturation ".....development is a continuous process. Beginning with conception, it proceeds stage by stage in orderly sequence, each stage representing a degree or level of maturity" (Gessell and Armatruda 1947). It was long claimed that a predetermined genetic sequence governed the orderly unfolding of motor ability in children. This had given rise to pessimistic beliefs about the unmodifiability of motor capacities in physically handicapped children.

Such an approach ignores the quality of movement responses, the idiosyncratic styles adopted by some cerebral palsied children to circumvent their motor disabilities, and leaves unexplored the whys of motor behaviour in young children. Nor does it take into account the effect motor training programmes have in enabling cerebral palsied children to achieve control over neuromuscular activity. In other words the descriptive or normative approach simply provides a chart of the developmental milestones.

Operational

A descriptive account must be followed by an analysis of the operations of motor behavior. The components of motor skills need to be identified and analysed, and the underlying mechanism that governs

skilled manipulative performance in children understood. It appears that the theories of skill development in terms of hierarchical ordering of components in act... have not been recognised and studied in CP children, except by Connolly and his associates.

Characteristics of a ...led act

A fresh analysis of the components and organization of motor skills is offered. Basically a prerequisite to the acquisition of skilled motor performance in the human subject, is its capacity to receive internal and external information, to store, code and analyse the information and its ability to issue commands to parts of the body to execute appropriate actions.

Sub-routines

Attempts to secure precise measures of motor performance are fraught with difficulties. It is suggested that recording qualitative changes in selected categories of children's manipulative ability is a more productive approach. Several components of the total action of functional activity, such as crawling, walking, feeding etc. can be examined. A basic segment of the total movement action is referred to as the sub-routine. It follows that skill can be assessed in terms of control, speed and precision with which a set of discrete motor acts must be learned, chained and executed in its correct sequence.

Sequence

Further analysis of the components of motor skill behaviour in cerebral palsied subjects are based on the work of Connolly (1968, 1970). Skilled movements therefore consist of an orderly series of linked sub-routines. These can be observed in such movements as running, writing, lifting, pouring from a teapot and playing tennis.

Feedback

The subject's ability to formulate and execute complex manoeuvres (movement patterns he has practised repeatedly) is mediated through an elaborate system of feedback.

Improvement in motor performance increases when a child is able to make adjustments between the incoming sense of information from his body (posture, balance, exertion, speed, space, the time element; quick or sustained, etc.) and the execution of a skilled movement. Movements

in themselves serve to inform the subject of the changes in environmental circumstances to reduce error in performance. Visual and non-visual and kinaesthetic feedback techniques to improve performance are widely used by physical educators in training students in ball games and athletics.

Subjects in receipt of abundant information prior to and during the performance of a motor task are claimed to acquire higher levels of skills. Learning, therefore is directly related to opportunities for rehearsing a skill and the subjects ability to make movement adjustments during performance. It can be argued that some cerebral palsied children fail to appreciate and maintain even the simplest movement skill, because of an inadequate feedback system.

Noise

While CP children need feedback from their own movements, they have difficulty in filtering relevant from irrelevant neuro-muscular activity. Connolly attributes the failure of some spastics to achieve adequate neuromuscular control, to "noise", (excess information) which masks the "signal" i.e. the essential message.

Active and passive movements

Certain types of contact with the environment are necessary for the development of sensori-motor ability. The question arises as to what kinds of motor experience facilitate its emergence. Some indications as to the best conditions that promote efficient visuo-motor, perceptive-motor and spatial skills in animals and human subjects appear in the studies of Held and Hein (1963), Held and Bauer (1967) and White and Held (1966).

The importance of self-induced movements in accelerating perceptuo-motor development was closely established. Active movements (movements which the subject, initiated, monitored and terminated) as opposed to passive movements, led to more efficient and normal visual-motor development in kittens, chimpanzees, dogs and infants. These findings raise important issues for educational practice and question the value of conventional forms of physiotherapy for motor handicapped children.

Motivation

Motivation in learning, especially in young children, is an important consideration, and it has a firm neurological basis. The brain cortex of a motivated learner will set the reticular formation of

the brain so that more information is perceived. Motivation however is not an easy subject for study because of the complex interaction between various motivating devices and the learner's self-motivation.

Learning a motor skill

Three broad stages in learning motor skills may be outlined:

1) "Cognitive phase" Plan formulation
2) Practice
3) Execution

1) *Plan*

The learner should have a clear concept of the goal and a suitable breakdown of the important components of the total skill to be learned. The individual should have an understanding of the serial organization of these discrete movements, and the correct order of operations to be performed.

At this stage the learner is obliged to take account of the normal constraints imposed on the human system. For example, there are the physical limitations of his sensory capacities, conditions of fatigue, psychological aspects of perceptual ability, such as deciding what cues to respond to, degree of vigilance to employ, etc., all of which are likely to affect his performance. In addition, the learner should possess the skill of ignoring irrelevant and redundant information ("noise" in information theory language) which is likely to distract him from carrying out a motor task.

2) *Practice*

Practice is an essential aspect of motor skill learning. It enables the learner to rehearse and master each of the units of the skill, and to reach the stage at which the organization and execution of such an activity is transferred to a lower cortical level (cerebellum) and movement patterns become automatic. Climbing stairs, eating ice cream, drinking soup, tying shoe laces, driving a motor car, are examples of such an organizational structure.

Some sequences, however, are separate units in themselves and can be practised independently of the total pattern. The kicking action of the "crawl" stroke in swimming can be practised on its own and outside the sequence pattern of arm, feet and breathing movements of the particular swimming stroke.

3) *Automatic execution*

This is the stage reached when the person performs motor acts with proficiency. The individual is able to carry out the correct

sequence of movements ranging from simple to complex ones with a minimum of errors, and without conscious effort. The value of relegating such tasks to lower levels of control lies in freeing the higher centres to deal with more complex additional requirements that might arise.

It should be pointed out that even when a skill becomes automatic some monitoring continues to occur and minor adjustments take place. When a familiar skill such as eating is practised, the diner might need to adjust the angle of his spoon or pressure of steak knife depending on the resistance of meat and plate.

Motor performance of Cerebral Palsied children

Normal children learn through motor activity and they depend upon an abundance of diverse and purposeful motor experiences to enable them to develop both physical and cognitive skills.

Damage to the immature or growing brain exposes the child to risks chiefly in respect of his capacity to learn, and to adapt his behaviour to diverse environmental encounters. In this respect CP children are disadvantaged because their motor ability is adversely affected and their access to motor experiences often grossly curtailed. As a result the range of activities performed by the children becomes severely restricted and largely predictable.

It is recognised that the motor behaviour of young CP children is relatively poor compared with that of normal children. The CP child is often slow, inaccurate, or unsuccessful in performing such simple tasks as walking, sitting, feeding, writing, etc. His performance is usually jerky and lacks fluidity of movement. These weaknesses may arise directly out of impared sensory processes, stemming from a disorder of the sensory apparatus, affecting vision, hearing, proprioception, kinesthesis, tactile and other modalities.

Certain processes, such as perception, attention, conceptualization, coordination and regulation of movement, features involved in motor skill performance, are often impaired. It is argued that the CP child is unable to integrate or fuse the various sub-skills into an efficient, orderly motor act, and that they commonly fail to combine and link the elements of sense reception, central processing (within the brain) and initiation of responses by the muscle groups, in order to achieve an efficient, smooth motor output. It is likely that disturbances in the input, information processing and output mechanisms give rise to disordered movement patterns.

CP children also are likely to have difficulty in handling an abundance of information. They tend to find it more difficult to focus their attention selectively to take in relevant information and to filter out irrelevant stimuli in the environment.

These and other weaknesses of higher cognitive ability (conceptualisation - mental rehearsal, perceptual discrimination etc.) combine to affect motor skills of CP children.

Conductive Education : some salient characteristics

The systematic training programme for CP children as laid down by the late Andras Pető (Conductive Education) appears to embody several significant features of efficient motor skill learning.

This view is based upon the writer's direct experience of the work carried out at the Institute in Budapest and on discussions about the rationale of the method with the Medical Director and her staff.

Briefly, the principal features of Conductive Education are as follows:

1) The setting of clear and realistic goals and overall plan of action for each child.

2) Recognition of and provision for individual variations in learning in CP children.

3) An operant approach to motor skill learning, in which existing movement patterns are enlarged by the skilful reorganisation of previously learned sub-routines, and reduction of possible failure by controlled presentation of new tasks to suit individual learning styles.

4) Training tasks carefully chosen for their positive transfer value.

5) High degree of temporal and spatial organisation of task sub-routines.

6) The meaningful use of conceptualising techniques.

7) The incorporation of adequate practice conditions to facilitate learning of the skill.

8) The use of speech as a guidance principle and for reinforcement for the movements *before* these actions are undertaken. In other words, the development of a set towards the movement is encouraged and reinforced by planned utterances and maintained by the rhythmic and practised speech content.

9) This is an active method of "motor education" and the connection between motor output and sensory output (which is lacking in the passive movement condition) is clearly established, enabling motor adaptation to take place more readily.

Summary

1) Repetition of a motor task helps in the automatic performance of a skill.

2) Smooth motor performance is dependent upon the integration of sensory information.

3) Motivation facilitates processing of efferent sensory information.

4) Knowledge of results is crucial for rapid and increased learning.

5) Comprehension and verbal instructions are a necessary background to skilled motor learning.

6) Rest intervals with a practice session do not necessarily enhance skilled performance.

Whilst it would be rash to generalise about the effectiveness of the Petö method being used at the Institute, especially as no evaluative studies have been carried out to date, the following impressions emerge:

a) The systematic programme of motor education (and in some instances re-education) has a sound neuropsychological basis.

b) There is a clear parallel between the Petö method and the application of operant conditioning techniques.

c) The precise delineation of goals, and the emphasis on teaching children learning strategies are some of the attractive features of this approach.

References

Connolly, K. Some mechanisms involved in the development of motor skills. *Aspects of Education*, 7, pp. 82-100, 1968.

Connolly, K., (ed.). *Mechanisms of Motor Skill Development*. London and New York : Academic Press, 1970.

Gessell and Armatruda, C.G. *Developmental Diagnosis* (2nd ed.), New York : Harper and Row, 1947.

Haskell, S.H., Barrett, E.K., and Taylor, H. *The Education of Motor and Neurologically Handicapped Children*. Croom Helm, London and New York : John Wiley. 1977.

Held, R., and Hein, A. "Movement produced stimulation in the development of visually guided behaviour". *J. Comp. Physiol. Psychol.* 56, pp. 872-6, 1963.

Held, R., and Bauer, J.A. Visually guided reaching in infant monkeys after restricted rearing. *Science 155*, pp. 718-20. 1967.

White, B.L., and Held, R. Plasticity of Sensori-motor development in the Human Infant in J.F. Rosenblith and W. Allinsmith. *The Causes of Behaviour : Readings in Child Development and Educational Psychology.* Boston, Allyn and Bacon, Inc. 1966.

SECTION TWO

WORKING PARTIES AND WORKSHOPS

Introduction

In the planning stages of this Eighth Annual Seminar in Special Education, the organizing committee had two essential objectives both of which would determine what the program would be, and who would be involved. These objectives were:

1. That this Seminar would be of a multidisciplinary character, bringing the expertise of educators, medical and paramedical workers and social welfare workers together in a profitable exchange of ideas. Section One of this publication has demonstrated a considerable success in the achievement of this goal.

2. That professional and non-professional people involved with the many facets of special education should be given an opportunity to come together in an atmosphere conducive to a maximum interchange of viewpoints. Section Two of this publication reports the outcome of this effort.

It is of paramount importance that readers should understand the intentions of the Seminar organizers in the planning and conduct of the Working Parties and Workshops. The freest possible interchange of ideas and opinions was being sought. Consequently, once Group Leaders had consented to fulfil such a demanding role, a minimum of restrictions as to how they conducted their groups was imposed - perhaps the most limiting factor was the time laid down in the Seminar program.

Key Persons were selected partly on the basis of suggestions from the Organizing Committee and partly by nominations from the Group Leaders. All Key Persons put forward by Group Leaders were accepted by the Organizing Committee.

The admixture of professionals, parents, foster parents and interested lay-persons which resulted from this "laissez-faire" policy was extraordinarily rewarding.

The high rate of attendance in all the working groups was sufficient testimony to the popularity of enabling this venue for an interchange of ideas to take place in a Seminar on Special Education.

The same lack of restriction that applied to the formation of the groups also applied to their manner of reporting. The only directions given to Group Leaders were that they should supply the Seminar Convenor with a summary of the group discussion and a list of recommendations for future action.

An inevitable consequence of this approach to conducting Working Parties and Workshops is that the resulting summaries and recommendations vary greatly in style, in emphasis and in length. It

has been a deliberate editorial policy to preserve this heterogenity in the written reporting of these group discussions.

It remains only to acknowledge the great interest shown by all Group Leaders and the preparatory work which they invested in assembling their key persons and their materials. There can be no doubt that the success of these groups will influence the thinking of organizers of future seminars in special education.

WORKING PARTY - GROUP I - HEALTH, EDUCATION AND WELFARE : GUIDELINES FOR THE FUTURE

Group Leader : Mr. B. O'Connor,
Lecturer,
Kelvin Grove College of Advanced Education,
Brisbane.

Key Persons : Dr. D. Fraser,
Paediatrician,
149 Wickham Terrace,
Brisbane.

Miss M. Outridge,
Principal Guidance Officer,
Queensland Department of Education,
Brisbane.

Sister K. Lannoy,
St. Joseph's Convent,
Kangaroo Point,
Brisbane.

Mr. R. Plummer,
Director of Children's Services,
"Kanrara", 64 Mary Street,
Brisbane.

Professor J. Ward,
Director of Special Education,
Macquarie University,
Sydney.

Chapter 13

HEALTH, EDUCATION AND WELFARE : GUIDELINES FOR THE FUTURE

Report from Group I

This Working Party used the first session to hear the key persons present their viewpoints on the topic. Participants were invited to note down themes which arose in the presentations and ensuing discussions. The following points were used as a broad "checklist" to help focus on some possible areas of concern:

1. *Service delivery*
   - adequacy of current services
   - gaps and duplications
   - sources of current services: - government
     - non-government
   - site of service delivery
   - target groups served
   - mode of delivery: unidiscriplinary ...interdisciplinary
   - other

2. *Administration*
   - policy making and stating
   - administrative structures: - government
     - non-government
   - coordination: - interdepartmental
     - government and non-government
   - other

3. *Personnel training*
   - professional
   - paraprofessional
   - parents
   - other

4. *Funding sources*
   - government: - federal
     - state
     - local
   - decentralized
   - public subscription
   - other

5. *Other areas/Personal observations*

In the concluding session, key persons chaired smaller working groups to deal with three themes that had arisen from the earlier presentations. These were a) change processes, b) service delivery, and c) responsiveness to people.

The recommendations are primarily at a general level. Though some specific issues were raised, time prevented a closer discussion. However, some key issues can be seen permeating the recommendations. These issues are:

1. HEW programs by their very nature should be people-centred with a caring focus.

2. As change involves people, both clients as well as personnel involved in the caring roles, the change process itself needs to be considered when new developments are planned.

3. Wherever possible, clients should be permitted an active, cooperative role rather than a passive role in service delivery.

4. Workers in the caring professions should recognize their own human limitations in dealing with all manner of clients or client groups within their own field of expertise.

5. Greater cooperation between individual professionals from different disciplines and/or agencies in the HEW field is a necessary prerequisite to improved cooperation between the agencies and disciplines themselves.

In reporting the recommendations, this writer wishes to acknowledge the contributions of the key persons, and other Working Party participants. Although the writer edited the wording and presentation format, it is hoped that the recommendations faithfully reflect the views intended by the group members.

Recommendations

1. *Change Processes*

1.1 That in planning for future developments in the Health, Education and Welfare sectors, due attention be given to strategies involved in the process of change.

1.2 That in tackling change, cooperative planning be carried out at macro- and micro-organizational levels.

For example, macro-organizational changes may involve a major re-arrangement of government and non-government administration and services with considerable inter-departmental cooperation. On the other hand, micro-organizational changes may be viewed as piecemeal attempts to rearrange services where necessary such as those within specific settings or agencies, or among those in a small geographical area.

1.3 That, in a spirit of seeking improved service delivery, the State government establish an independent task force or Commission of Enquiry, comprising independent members and departmental officers in the HEW areas (a) to examine such aspects as existing legislation, administrative structures and policies, and service delivery systems in government and non-government HEW fields and (b) to recommend innovations which will provide greater efficiency of effort and improved services to clients.

1.4 That, in planning for future developments, due attention is paid to the ascertainment of need within the community, that the perspectives of need are clearly defined, and the information upon which decisions are based is also clearly presented.

For example, perspectives may derive from ideological or political motives, from sectional interest groups, from professional opinion, from institutions (home, school...), or from neighbourhood groups.

2. *Service Delivery*

2.1 That an integrated HEW program be developed which will cater for handicapped persons from birth to adulthood within a continuum of service.

2.2 That an early and efficient system of diagnosis be established entailing appropriate screening programs conducted by appropriately trained personnel who will refer children to agencies for detailed diagnosis and follow-up treatment.

2.3 That an examination of the needs of special groups or geographic areas be undertaken to determine the most appropriate format for service delivery.

For example, it may be that appropriately trained family GP's may act as a convenient initial contact point whereas local community health centres may better serve the needs of some people such as those who tend to spend long hours in agency waiting rooms escaping the reality of their home environment. Services in sparsely populated country areas may well require a different format from those available in larger cities.

2.4 That a coordinated effort of public education be undertaken by HEW departments and related non-government agencies to provide accurate information about handicapping conditions and services available, and to promote improved community attitudes to the handicapped.

2.5 That parents be given access to accurate information about their child and that appropriate distinctions are made between clearly established and inconclusive diagnoses.

2.6 That, whilst safeguarding the rights and privacy of the client, appropriate procedures be established for access to information about the client's condition that is considered necessary by other professional personnel for diagnosis and treatment programs.

3. *Responsiveness to people*

3.1 That agencies and their professional employees recognize the limitation of their capabilities to deal with certain individual and community problems and seek alternative approaches to overcoming the threat and alienation frequently engendered in some clients from contrasting experiential and social value backgrounds.

3.2 That programs of parent training be established in areas of special need in order to prepare families to follow through programs developed by professional personnel.

3.3 That consideration be given to training sub-professional personnel to assist families with intervention programs in the home setting.

3.4 That in agency services, continuity of treatment/service be provided by the one professional person as far as possible, over an extended period of time.

3.5 That professionals across disciplines receive appropriate pre-service and in-service training to develop -

(a) team building skills, and
(b) recognition and understanding of the strengths and limitations of each group's knowledge base and skills.

WORKING PARTY - GROUP II - MEDICAL, EDUCATIONAL AND WELFARE RESEARCH NEEDS IN EDUCATION

Group Leader : Mr. J.A. Burge,
Principal,
State School for Spastic Children,
Brisbane.

Key Persons : Dr. R.J. Andrews,
Acting Director,
Schonell Educational Research Centre,
University of Queensland,
St. Lucia, Brisbane.

Mr. R. Campbell,
Guidance Officer,
Queensland Department of Education,
Brisbane.

Dr. W. Domville-Cooke,
Queensland Children's Research Foundation,
Brisbane.

Dr. A.E. Dugdale,
Paediatrician,
Mater Children's Hospital,
Brisbane.

Sister M. North,
School Health Services,
Brisbane.

Mr. P. North,
Senior Tutor,
Department of Social Work,
University of Queensland,
St. Lucia, Brisbane.

Mrs Jill Volard,
Tutor, Department of Social Work,
University of Queensland,
St. Lucia, Brisbane.

Contributions from the following key persons are appended :
Mr. Rod Campbell
Dr. W. Domville-Cooke
Dr. A.E. Dugdale
Mrs Mary North
Mr. Peter North
Mrs Jill Volard

Chapter 14

MEDICAL, EDUCATIONAL AND WELFARE RESEARCH NEEDS IN THE EDUCATION OF CHILDREN

Report from Group II

The attempt to outline problems, from three disciplines, which demonstrate research needs in the education of children brought forth several difficulties which exhibited themselves at a number of levels. Two themes were constantly encountered at all levels of interaction, namely;

1) communication problems: (a) between individuals of different training; (b) between groups or institutions who conduct research; and (c) between government departments responsible for a range of public services.

2) the difficulties posed by data collection and data sharing. In particular, approaches to long term record keeping and retrieval of data which are universally useful, and the problems of understanding and supplying acceptable data to all participants in a cross disciplinary exercise.

Research needs appeared to structurally place themselves on a continuum, which began with the workforce requirements of an individual child and proceeded to larger conglomerate problems, expressed in such terms as the delivery of educational, or health services on a community, state, or national basis.

At the individual child level, several needs were outlined by the working party with recommendations for research action. They included the need to sensitize teachers to the basic health problems and their first level effects on school performance so that immediate and fruitful cooperation could take place to eliminate common physiological causes from everyday school learning problems. These suggestions ranged from the recognition of basic malnutrition and sensory loss to more hidden areas such as colour deficiency.

At the group level several local problems were outlined. The need to thoroughly investigate the problems of urban living and its effects on schooling were outlined with particular relationship to some local Brisbane locations now demonstrating the characteristics of inner urban locations. The problems of delivery of service to children in corrective institutions and their re-acceptance into local school life were outlined with a recommendation for research action. A plea was heard to investigate and especially detail, the advantages and disadvantages, of integration of physically and mentally handicapped children into regular schools.

It was readily agreed by the working party that various disciplines could learn much from each other by the manner in which they undertook research, and generally viewed problems. The participants with social work background described the advantages of a holistic approach to problem investigation. Medical personnel explained the need to always be conscious of the effects of basic physiological and metabolic functioning and their ramifications before pursuing possible secondary causes. Teachers pointed out the need to differentiate the difficulties according to the multiplicity of factors found in the classroom and general school environment.

In summary, it was universally agreed that joint research programs involving different disciplines were necessary and desirable. Whilst communication problems would be encountered, caused by different training and approaches, they were not insurmountable and should be readily overcome in a research atmosphere where goals were clearly defined.

Summaries of some of the suggested topics displaying research needs are attached.

APPENDIX

Relationship between Nutrition and Educational Performance

A.E. Dugdale

There is considerable literature relating poor nutrition to poor educational performance, but in most published work this relationship is taken in isolation. I have evidence to suggest that nutrition itself may play a relatively small part in the school performance, but that the social and economic conditions associated with malnutrition are likely to be much more important.

The Health of Aboriginal Children and their School Performance

A.E. Dugdale

Aboriginal children have a large amount of ear disease from infancy onwards and this appears to reduce their verbal skills. This, in turn, makes education in a normal classroom more difficult. The medical aspects of ear disease are being investigated and treated, but the overall medical policy in relation to education can well be discussed.

The Educational Significance of Colour Deficiency in Children Vision

Mary North

From my observation of colour deficient children, I feel they can be educationally handicapped and from the frustrations they experience, emotional problems can occur. For these reasons a screening list of colour vision would seem an appropriate part of initial pre-school examination. Early recognition of any handicap is important, as it enhances the possibility of good school experiences, on the other hand unrecognised handicap leads to frustration, rejection, failure or punishment and confused and unfavourable feelings towards school may result. A closer assessment of the educational attainment of colour deficient children, related to their IQ's and the teaching procedures to which they have been subjected, seems an important research need.

Communication between Doctors and Teachers in the treatment of children's health and school related problems

W. Domville-Cooke

Teachers and medical personnel frequently work in isolation with the same child. Communication would improve the service to the child. The preparation and skills of both teachers and doctors needs to include the building of skills and awareness in this area. Research could tell how this might best be tackled.

The Significance of General Health in the Education of Children

W. Domville-Cooke

Awareness of the significance of general health to educational progress is limited. Analysis of the significance, through research, may demonstrate the importance of this factor and allow it to become a regular part of routine in ascertaining the causes of school learning problems.

Parent's Role in the Educative Process

W. Domville-Cooke

Parents play an important role in both formal and informal educative procedures. They have little or no formal training for this role. Research may assist in demonstrating the most effective ways in which parents can guide their children's progress and allow them to be efficient educators.

A Welfare Perspective

Jill Volard
Peter North

1. That two or three primary schools in Brisbane be used as experimental model situations for the integration of both physically and mentally handicapped children into the normal school setting, with provision of the necessary staff and physical plant resources to meet their particular needs.

2. That a number of schools implement a multi-disciplinary approach so that the complex relationship that exists between the child, his family and his ability to cope with the school situation be investigated. Already some groups within the school system are recognized as having particular needs - the minority group child, the socially disadvantaged child, the acting out child. However it seems that the potential of the school to serve all aspects of the child's developmental needs is not realized. Given a more holistic approach to service delivery, the educational setting could provide a direct preventive service to child, family and community.

A suggestion for collaborative research

Rod Campbell

1. Conduct a survey into the present provision of medical, educational and welfare services to children who come under the care and control of the Children's Services Department and/or the Department of Welfare and Guidance.

2. Assessment of educational standards of these children.

3. Survey educational provision for those children attending local schools while under the care and control of the Children's Services Department.

e.g. Warilda	_____	Wooloowin State School & Kedron State High School
Marsden	_____	Kallangur State School & Pine Rivers State High School
Enoggera	_____	Enoggera State School & Everton Park State High School
Alkira	_____	various schools

4. Survey of teachers attitudes towards these children:

   (a) teachers in above schools

   (b) teachers in adjacent schools

5. Provision of improved liaison service between the agencies and schools about individual children.

Colour deficiency and education

Mary North

I quote R.L. Gregory, Cambridge University, Department of Psychology: "It is all too easy in thinking about vision to concentrate on the eye and forget the brain."

The study of colour vision is an off shoot from the main study of visual perception. It is certain that no mammals up to the primates possess colour vision - if some do - it is extremely rudimentary.

What makes this so strange is that many lower animals do possess excellent colour vision. It is highly developed in birds, fish, reptiles, and insects such as bees and dragon flies.

We attach such importance to our perception of colour - it is central to visual aesthetics, and profoundly affects our emotional state - that it is difficult to imagine the grey world of other mammals, including our pet cats and dogs.

What of our colour defective children in their early school years experiences, where they are taught in a world exploding with colours? I feel they have been seriously overlooked.

Colour chalks on boards (usually referred to as blackboards but mostly green), coloured rods, story picture books, sounds taught in colour, instructions and symbols in colour, and in some schools, "Words in Colour".....

Does the C.V.D. child experience a typical stress in acquiring academic skills because of his inability to perceive colours normally?

The limited ability of colour defective children to discriminate between certain hues in incontestable - it is the essence of the condition.

The C.D. child has fewer "notes in his scale than the normal child" so that there is a definite deficiency - not just a difference.

This deficiency in colour discrimination may be likened to a partial hearing loss. The child of good intelligence who has difficulty in distinguishing all the sounds of speech develops a remarkable set of compensating mechanisms; he lip reads more and better than the rest of us, he fills in imperfectly heard words by assessing their context, and by using visual clues and associations of various kinds.

He may achieve near normality, but frequently displays irritability, or other evidence of strain of continuous attention and guessing which is imposed upon him. His case is far worse if his deafness is not *known* to or *remembered* by those about him, so that he is blamed for any incorrect interpretations he may make. If he is not clever, or lacks application, he may fail to compensate for his hearing loss, and drop back in the educational race. To what extent can it be said of the C.V.D. child?

He undoubtedly has analogous problems: at any age when the normal child is discriminating between colours and learning their names, in some cases he knows where he is with some colours and names, but with others he may find a series of names applied to what he sees as *one hue*, or to what he may even have difficulty in seeing at all. If he is intelligent he soon learns to avoid mistakes - or rather, to avoid being seen to make mistakes - by using context and clues of various sorts. He learns what colour names to apply to various components of his environment - to call grass and other foliage green, brick work red and soon and *above all* to keep quiet, and await events, if he is not sure. This is where he scores over the child with a hearing loss. Speech is such an essential and continuous part of communication and learning that the deaf child *cannot* hide his disability.

It has often been said that C.V.D. children quickly learn to overcome their difficulty - one suspects that what they really learn is to hide it.

With the colour defective child as with the partially hearing child there may be greater problems if the defect is not *recognised*.

Thurline (1964) screened an entire school district of 10,341 students for C.V. deficiency and reported a higher incidence of referrals of C.V.D. students to the psychologist for behaviour problems in kindergarten and first grade than children with normal vision. He further reported the possibility that using colour in teaching techniques places the deficient in an unrecognised disadvantage which can result in behavioural patterns warranting referral to the psychologist.

In the course of my work it disturbs me to find how unconcerned the usually conscientious teacher is when one informs them that certain children are colour defective. They do not relate this disability to something which could contribute to the child underachieving, in the same way as when informed of a hearing loss or imperfect vision.

Miss MacKinnon of the Psychology Department, Glasgow University, states the difficulty is to get the primary school teachers to understand how *real* the problem is. It is important to realize that colour is NOT there merely to create interest, but is used *functionally*, so that a failure to distinguish colours must result in a failure to understand the significance in all work in colours.

There must be at this stage an assurance given that this attitude does not in any way lower a regard for the teaching profession. Indeed, after good parents it is considered that they surely must be the most important people in the world.

The teachers should be alerted in their training days to this problem, that colour defectiveness may be a potential inhibiting factor in a child's progress.

The importance of discovering any handicap which a child may have *before* entering school is widely recognised. Screening *all* children for C.V.D. should be included in all pre-school examinations and in first grade.

A closer assessment of the educational attainment of C.V.D. children, related to their I.Q.'s and the teaching procedures to which they have been subjected seems an important research need.

Similarly if C.V.D. children are subjected to stress and frustration one might expect to find evidence of this in referrals to Child Guidance Clinics.

References to -

1. C.V. Screening Pre-school etc. - J.R. Gallagher and C.D. Gallagher, Boston. Vol. 72 Aug. 1974. Archives of Ophthalmology.

2. Journal of Learning Disabilities - Vol. 64 No.3 March, 1973 by Stanley D. Espinda, Ph.D.

3. Colour Vision Defect - An Educational Handicap by Lionel Bacon, M.D., DPH, Medical Officer, 16th April, 1971.

4. An Advisory Clinic for C.D. children - W.O.G. Taylor (Ayr).

WORKING PARTY - GROUP III - NORMALIZING THE EXPERIENCES OF HANDICAPPED CHILDREN

Group Leader : Dr. Paul Berry,
Senior Lecturer,
Schonell Educational Research Centre,
University of Queensland,
St. Lucia, Brisbane.

Key Persons : Dr. Irene Apel,
Psychiatrist,
131 Wickham Terrace,
Brisbane.

Sr. Margaret Evans,
St. Vincents Home,
Queens Road,
Nudgee.

Mr. D. Smith
Department of Children's Services,
Queensland.

Mr. P. Wilson,
Department of Children's Services,
Queensland.

Chapter 15

NORMALIZING THE EXPERIENCES OF HANDICAPPED CHILDREN

Report from Group III

A move towards normalizing the experiences of the handicapped was a main thrust of research work and change in service delivery for the handicapped since the early 1960s. Such a policy stated that, as near possible, all services and attitudes should be provided for the handicapped as they are for 'normal' citizens. The handicapped, therefore have basic rights - to education, to home-like living conditions, to a wage, to work and so on. Indeed, this movement led to bills of rights for the handicapped and to a series of far reaching court cases in the United States producing legal precedents for 'normalizing' experiences and services. In the light of such a philosophy of handicap, the following recommendations were made by the group:

1. That all handicapped children have the right to education, which is to be provided by education authorities.

2. That the aim of education of handicapped children is to enable them to cope with experience in a normal situation (for example, The Special School of Dance).

3. That where appropriate, segregation of the handicapped child is to be reduced to the extent that this can be achieved.

4. That handicapped children are not to be excluded from acquiring the social skills which enable them to participate in society.

5. That educational experiences of children need to involve material relating to handicapped people.

6. That adequate caring and treatment is to be given handicapped children. This minimizes their handicap.

7. That buildings be of appropriate design to provide entry for physically handicapped children.

8. That the general public be presented with an education program.
   Points: - handicap does not exclude children from participating in society.
   - Normalizing experiences for handicapped children also have an educative value for the general public.
   - Use of the media to include programs that show handicapped people functioning adequately.

9. That family support services for families with handicapped children need to be developed.

10. That employment possibilities for the handicapped need to be opened up in the Government Departments as well as in private enterprise.

11. That appropriate research is to precede and inform policy changes in the education of handicapped children.

12. That investigation be made regarding the most efficient way to collate and distribute information regarding the facilities available for handicapped children including a centrally integrated At Risk Register.

Further reading

Berry, P., Andrews, R.J. and Elkins J. (1977). The evaluation of residential,educational and vocational services for the intellectually handicapped. Report to the Department of Social Security, Canberra.

Wolfensberger, W. (1972). The Principle of Normalization in Human Services. National Institute on Mental Retardation : Toronto.

WORKING PARTY - GROUP IV - EDUCATIONAL PROGRAMS FOR CHILDREN IN RESIDENTIAL CARE

Group Leader : Mr. W. Brown,
Staff Inspector,
Guidance and Special Education,
Department of Education,
Brisbane.

Key Persons : Mrs. H. Cryle,
North Brisbane Regional Guidance Office,
Chermside, Brisbane.

Mrs. A. Grant,
"Kalimna"
Toowong.

Mrs. D. Gleeson,
6 Wonga Street,
Inala.

Dr. I. Phillips,
Institute of Child Guidance,
Rogers Street,
Spring Hill, Brisbane.

Sister C. White,
St. Vincent's Home,
Queens Road,
Nudgee.

Chapter 16

EDUCATIONAL PROGRAMS FOR CHILDREN IN RESIDENTIAL CARE

A Report from Group IV

Preliminary discussion lead to a decision on format:

(i) Morning discussion lead to a decision on format.

(ii) Afternoon discussion to be used for more detailed discussion on programming.

Residential care was taken as embracing the following types of governmental and non-governmental institutions:

(a) Corrective - closed institutions.
(b) Treatment institutions, e.g. Wilson Youth Hospital, Kalimna.
(c) Remand/Assessment institutions.
(d) Reception/Assessment.
(e) Residential with internal school, e.g. Spastic Centre, Boys' Town, Montrose, Xavier.
(f) Residential - children going to external schools.

Education? What should it embrace?

(a) Social
(b) Academic
(c) Cultural

1. Should cover all *NEEDS* of the child as above.

2. Reference was made to *SURVIVAL needs* of children with little experience of operating as social beings in the society beyond the institution.

3. *Educational programs* should compensate for child's areas of deprivation.

4. There was need for the child to receive *stimulation* and to express his latent creativity.

5. *Language* and *communication* skills were regarded as requiring particular attention.

6. The *personality development* of each child was regarded as paramount.

7. *Early Intervention* was treated as an important issue but could not be universal because many children were now coming into care when they were older (e.g. 10 - 11 years).

8. There was discussion on the setting up of an area of Special Education to be devoted solely to the *SOCIALLY HANDICAPPED.*

9. *Teacher effectiveness training programs* were discussed as was the possibility of the appointment of a *special officer* to *liaise* between the institution and the school because it was felt that teachers did not fully appreciate the problems of the institutionalized child.

General discussion continued along the lines set down above with the following additional points being brought forward.

Approaches to programs should be *innovative* to provide better motivation for those undertaking them.

The following points in regard to educational programs may be said to summarize the thinking of this group:

1. The government was to be commended for the initial steps taken to fund such programs and it was stressed that these should be *ONGOING.*

2. The practice of asking each institution to make individual project recommendations was also to be commended and is one which should continue.

3. There was felt to be a need for *support services* from professionals (e.g. Remedial/Resource Teachers, Speech Therapists, O.T's) to improve the children's scholastic skills and to increase their independence and self reliance.

4. It was felt that a particular area of *Special Education* might attempt to cater more adequately *for the socially handicapped.*

5. The *"half-way house" scheme* of placing children with specially trained 'house parents' or foster parents within a small family setting was put forward as a possible aid for the *emotionally disturbed* child.

6. *A teacher 'supervisor'* working in conjunction with house parents might decrease school problems for the child in residential care and assist house parents when such problems arose.

7. The possibility of *teachers* working in schools attached to institutions *working 'flexi-time'* could assist in (7) above and also assist children to gain social skills and everyday living experiences.

8. The *multidisciplinary approach* to the program, e.g. Health Education Welfare was stressed throughout.

9. It was felt that the child in care gained great benefit from attendance in a school beyond the institution as it furthered community education and led to greater acceptance.

10. It was felt that the '*hidden costs*' of education e.g. sending money with the child for trips, excursions etc. added to the problems of those caring for the children.

11. Suggestions were made for the *setting up of interdisciplinary* advisory committees to assist in developing programs.

WORKING PARTY - GROUP V - EARLY INTERVENTION AND HANDICAP

Group Leader : Mrs. Johanne Wright,
Acting Psychologist-in-charge,
Central Assessment Clinic,
Brisbane.

Key Persons : Mrs. J.G. Andrews,
Principal,
Radford House,
Buranda, Brisbane.

Mrs. V. Dawson,
Department of Speech and Hearing,
University of Queensland,
St. Lucia, Brisbane.

Mrs. I. Castner,
Senior Speech Therapist,
Guidance and Special Education,
South Brisbane.

Mrs. M. Ellis-Robinson,
President,
Childhood Language and Related Behaviour
Disorders Association,
Brisbane.

Professor J. Rendle-Short,
Professor of Child Health,
University of Queensland,
St. Lucia, Brisbane.

Mrs. P. Savage,
President,
SPELD,
Milton, Brisbane.

Participating : Mr. I. Anderson
Mrs. M. Hewitt
Mr. R. Long
Mrs D. Knudsen
Mrs R. Webster
Mrs S. Whitton

Chapter 17

EARLY INTERVENTION AND HANDICAP

Report from Group V

Evidence from studies on animals, from studies on the central nervous system of infants and from studies of the effect of stimulating environments on children has lead to sustained interest in the field of early intervention in handicapping conditions to minimise the effects of these conditions on certain children.

This current thrust toward early intervention requires new approaches toward the detection and assessment of children at risk for handicapping conditions. This places new demands on both educational and health services available in the community.

A number of issues relating to development of appropriate early intervention programs were raised by parents of handicapped children who have faced problems in relating the services they need both for themselves and their child. These were:

1. The delivery of primary health services.
2. Training of professionals.
3. Parent involvement.
4. Community awareness.

1. *The Delivery of Primary Health Services*

It was generally recognised that the primary professional likely to have the first contact with a child at risk was a medical practitioner. However, many families experience problems in both receiving adequate information about their child's condition and being told of community and educational facilities available to help their child.

The difficulties of communication and cooperation between the health and education fields were attributed to be responsible for this problem as well as the traditional conservatism of both sets of professionals in accepting innovative approaches to the problem.

In addition, the problem of time spent in obtaining an adequate medical diagnosis which would satisfy medical practitioners often precluded the implementation of an early intervention program. Thus there was frequently a mismatch between medical and educational services with different priorities and aims being established.

It was therefore recommended that the following occur to minimise these problems:

1.1 The establishment of better liaison between health, welfare and education departments via joint planning committees.

1.2 The establishment of better liaison between health, welfare and education professionals via joint seminars, and post-graduate courses.

1.3 The development of multidisciplinary assessment centres, where close interdisciplinary cooperation and contact ensures more adequate assessment of a child's condition.

1.4 Freeing of referral systems so that such centres would not be solely reliant on medical referrals.

1.5 Development of more appropriate referral mechanism to prevent duplication of assessments and to ensure rapid referral to an appropriate agency.

1.6 Development of assessment procedures which are functionally oriented and provide information about a child's strengths and weaknesses upon which an educational and therapeutic program can be designed.

2. *Parental Involvement in Training*

This issue was discussed in some detail and was obviously of prime importance in providing adequate early intervention programs. Many parents felt isolated and ignored by professionals and few appeared to be totally involved in all aspects of their child's treatment and education.

A number of recommendations to improve this were made:

2.1 Parents should be fully informed by professionals as to the problem, assets and needs of their child.

2.2 Parents should be fully informed of available services for their child.

2.3 Parents should be trained in methods of assessing and treating their child.

2.4 Parents should be involved in the decision making about their child's treatment and be included as a member of the multi-disciplinary team.

3. *Training of Professionals*

Frequently throughout discussion the problem of inadequately trained professionals was raised as a reason for lack of good quality intervention programs.

The recommendation for improved training included:

3.1 Increased emphasis on communication and counselling skills to medical students.

3.2 Increased emphasis on problems of handicapped people in training of all professionals.

3.3 Post-graduate and inclusive training courses on handicap for professionals.

3.4 Development of more relevant training courses for teachers of handicapped children.

4. *Community Awareness of Handicap*

The problems faced by many families with handicapped children are exacerbated by poor community attitudes toward handicap. There was general agreement that improvement of programs for handicapped children require a concomitant improvement in community acceptance.

Some ways in which community awareness can be increased include:

4.1 More effective integration of handicapped children into the community, in playgroups, pre-schools and schools.

4.2 Increase in services to all areas of the State to ensure that community programming can be initiated.

4.3 Use of media to discuss and explore issues related to handicap.

4.4 Involvement of parents in making the community aware of their child's needs.

Overall, the recommendations focussed on the need for better awareness of both lay and professional persons alike as to the needs of handicapped children. The emphasis on improved attitudes and training of people in the field was equally balanced with the strong recommendation to involve parents in all aspects of their child's treatment as the only effective mechanism for ensuring appropriate and successful intervention.

WORKING PARTY - GROUP VI - THE ROLE OF HEALTH SERVICES IN SCHOOLS

Group Leader : Dr. V. O'Hara,
Director,
Division of School Health Services,
Brisbane.

Key Persons : Mrs J. Carusi,
Principal,
Mt. Gravatt Opportunity School,
Mt. Gravatt, Brisbane.

Dr. S. Latham,
Deputy Medical Superintendent,
Royal Children's Hospital,
Herston, Brisbane.

Mr. I. Loveluck,
Department of Children's Services,
Brisbane.

Mr. G.J. Swan,
Inspector of Schools,
Queensland Department of Education,
Brisbane.

Dr. J. Vance,
Paediatrician,
Mater Children's Hospital,
Brisbane.

Chapter 18

THE ROLE OF HEALTH SERVICES IN SCHOOLS

Report from Group VI

1. The Working Party agreed that the staff establishment of the School Health Services should be enlarged considerably.

2. Training of School Sisters should be extended to include more emphasis on the detection of psychosocial conditions and even consideration to some treatment in isolated areas where the Sister is the only health professional available in the community.

3. Other dimensions which could be added to the health services in schools could be the assistance of physiotherapists, occupational therapists, speech therapists and others to work with and in fact be on the staff of School Health Services. This latter recommendation is desirable because of the possibility of litigation when such personnel are employed by the Department of Education.

4. The emphasis of the school medical examinations in Queensland should change. This was recommended unanimously. School Health Services emphasis should include:

   (a) More parental involvement.

   (b) More emphasis on the Pre-school and State School entrant age groups.

   (c) More involvement with adolescents with a Sister perhaps being stationed at a High School and doing health appraisals of the children attending the Pre-school and State school that feed that particular High school.

   (d) More research e.g. into nutrition. Research hopefully involving allied health and educational professionals.

5. More emphasis on teaching Health Education to children, parents, informal discussions with teachers and in the long term, medical students and other therapy students attending the universities.

6. The structure of the service should be clearly defined so all Government Departments and other agencies are familiar with it and this would involve more communication at all levels and in all directions.

7. Health Services should be extended to those children where it is believed there is a disproportionate number of unsuspected disabilities, e.g. Boys' Town, Wilson Youth Hospital, Multicap, The School for Autistic Children among others.

WORKING PARTY - GROUP VII - HOMEBOUND CHILDREN

Group Leader : Mr. N.R. Culbert,
Co-ordinator of Education for Physically Handicapped Children, Queensland Dept. of Education,
Brisbane.

Key Persons : Ms. K. Bayard,
Paediatric Psychotherapist,
Royal Children's Hospital,
Herston.

Sr. R. Hamlyn-Harris,
Residential Sister,
Montrose Home,
Corinda.

Mrs P. Johnson,
Director,
Noah's Ark Toy Library,
New Farm.

Mrs J. Norton,
Teacher/Librarian,
Royal Children's Hospital School,
Brisbane.

Mr. A. Sandaver,
Principal Child Care Officer,
Department of Children's Services,
Brisbane.

Ms. D. Wallace for Miss R.N. Shepherd,
Officer-in-Charge,
Central Assessment Clinic,
Brisbane.

Mrs R. Turner,
Social Worker,
Spina Bifida Association of Queensland,
Brisbane.

Contributions from the following key persons are appended :
Mrs J. Norton
Mrs P. Johnson
and also from Miss R. Shepherd who was unable to attend.

Chapter 19

HOMEBOUND CHILDREN

A Report from Group VII

A. Population of homebound children

1. Congenitally intellectually and physically handicapped children aged 0 - 3 years.

2. Pre-school aged developmentally delayed children who cannot attend a regular pre-school and for whom special pre-schools do not currently exist.

3. School-aged moderately and severely intellectually handicapped children on waiting lists for special schools.

4. Multiple handicapped children who do not gain a place in existing special schools.

5. Physically or emotionally delicate children who would be endangered by school attendance (e.g. haemophiliacs, asthmatics, cardiac disorders).

6. Children convalescing after hospitalization for a short-term or long-term fractured femur, brain stem injury and burns cases.

7. Emotionally disturbed children (e.g. school phobic, pre-psychotic and encopretic conditions) who have been suspended from school attendance.

8. Children of migrant, retarded or socially disadvantaged parents who are unaware of or unwilling to use existing special education facilities.

Action statements

1. Collection of statewide data relative to the numbers and characteristics of homebound children.

2. An encompassing statement of desirable philosophical objectives and organizational structure for homebound services.

3. A determination of essential and ideal teacher competencies and preparation.

4. The delineation of successful educational programs and strategies for all levels from infancy to adulthood, including recreational programs.

5. Mount a PR campaign to increase lay and professional appreciation and understanding of these services.

6. Instigation of a co-ordinated and broadly constituted basic and applied research effort.

7. (a) Establishment of educational "at risk" registers
   (b) Establishment of a clearing house of information from medical agencies to educational authorities for "at risk" children.
   (c) Provision of multidisciplinary assessment and family support teams to deliver house-based early intervention programs.
   (d) Provision of more special pre-schools for severely handicapped children.
   (e) Provision of educational play equipment libraries around the state. (e.g. Expansion of facilities of Noah's Ark toy library).
   (f) Provision of more play groups for young severely handicapped children (e.g. Expansion of activities of the Association for the developmentally young).

8. Provision of home visiting teachers sufficient to serve homebound children at pre-school and school level. Children from remote areas should be served either by correspondence programs or by their boarding in the cities during school term.

9. Provision of relief placements for parents of homebound children through - suitable family group or foster homes
   - expansion of the Volunteer Neighbour Service
   - expansion of the Home Help Service

10. Assistance to parents in the form of payment of transport costs to special pre-schools or payment of mileage allowance to volunteer drivers.

11. Investigation of the feasibility of teaching homebound children by telephone as an adjunct to home visits.

12. Representation to the Office of Child Care, the Schools Commission and government departments regarding adequate funding of the above programs.

Assumptions underlying teaching for homebound children

1. The education of children who are homebound is the responsibility of the Department of Education.

2. The program is one of inclusion in a school program, not exclusion.

3. Teachers in the service of these children are certified classroom teachers with additional specialized preparation in special education.

4. Teaching these groups of children is a regular part of the teachers' work load; it is not an after-school salary supplementer or charitable effort on behalf of the underprivileged.

5. Educational programs for the homebound need supervision and direction from qualified and knowledgeable educational leaders.

6. Education should occupy a distinctive place in the lives of the children because of its normalizing and therapeutic values.

7. Children confined to their homes do not usually perform educationally as well as they can and should.

8. The inescapable individualization of instruction presents a unique opportunity to start at the basal level at which the child functions comfortably, to fill in the learning gaps and to encourage intellectual curiosity, exploration, experimentation and forward movement.

9. Home instruction can foster accelerated educational progress as well as promote remediation.

10. Inherent in this specialized teaching is extraordinary teacher freedom for experimentation, creative instruction and the cutting of new pathways for education generally.

11. For optimum educational programs for children who are homebound, teachers require a working relationship and effective communication with members of the interdisciplinary team concerned with their pupils.

(Adapted from Connor, F.P. "Education of homebound or hospitalized children.)

B. Agencies currently providing services for homebound children in Queensland

1. *Division of Special Education, Department of Education.*

(a) For hearing-impaired children.

A home-based early intervention program is offered to families of young hearing-impaired children immediately on diagnosis and

referral to a special pre-school for the hearing-impaired. Such pre-schools currently operate at Yeerongpilly, Zillmere North, Ipswich, Toowoomba, Rockhampton, Townsville, Cairns and Mt. Isa.

(b) For visually handicapped children.

A home-based early intervention program is offered to families of young visually handicapped children immediately on diagnosis and referral to Narbethong school and Hermit Park Unit in Townsville.

(c) Royal Children's Hospital School.

Since 1973 a home visiting service has operated from the Royal Children's Hospital School for children unable to attend a school. In some cases this service supplements lessons from a Correspondence School. In other cases it provides the child's only educational program. Admission to the scheme is through the Principal and/or the Guidance and Special Education Branch following medical recommendation that the child is unable to travel to a school.

2. *Central Assessment Clinic, Division of Psychiatric Services, Department of Health.*

The Central Assessment Clinic provides a wide range of assessment and domiciliary support services for intellectually handicapped children including psychologists, therapists, teachers, a recreation officer and a social worker.

3. *Queensland Sub-normal Children's Welfare Association.*

The Association employs teacher home counsellors to provide home support to parents of intellectually handicapped infants and toddlers.

4. *Noah's Ark Toy Library.*

5. *Department of Children's Services.*

The Department provides services to parents as well as children where there is need for such counselling.

6. *Queensland Spastic Welfare League.*

Social work support for parents as well as home programs for therapists are provided by the League to a wide range of centre-based services at New Farm.

C. Rationale for home visiting services

1. *Young handicapped children*

The parents are the primary influence during the early formative years and provide the necessary warm intimate and continuous interaction with the child that no professional could emulate. Parents are not trained in the child-rearing skills associated with typical, much less atypical children. Severely handicapped children often need to be taught to eat, to drink, to walk and they need to be toilet trained. Many handicapped children need to be taught to play and to be given specific help in acquiring language skills in a way that ensures that they gain pleasure and satisfaction as well as an understanding from these activities.

In addition to the skills necessary for daily living, young handicapped children need an enriched environment to foster optimal growth and development. Therefore it seems logical for parents to be given more expertise in dealing with these children, thus enabling them to become more effective in furthering their development. An important outcome of this course of action is the building up of the mother's confidence in her ability to advance her child's independence and in so doing, her own self-esteem with beneficial effects for the whole family.

A variety of professionals may be involved in a domiciliary program and the need for a coordinated approach to the family is paramount. Doctors, social workers, therapists and psychologists are needed to complement the work of home visiting teachers.

Domiciliary programs should not be viewed as a substitute for educational experiences outside the home. Every effort needs to be made to socialize the child through activities such as playgroups and through more informal contacts. One of the most significant deficits in the experience of homebound children is the lack of peer contact and resultant immaturity in cognitive and social skills together with a poorly developed self-concept. Compensatory activities need to be deliberately planned in advance to offset potential developmental imbalance.

2. *Children unable to attend a school.*

It should be stated emphatically that the preferred educational setting for school-age children is the school not the home. As with young homebound children those of school-age miss out on the enriching experiences of peer involvement. Opportunities for vicarious learning which exist in a school day routine are also denied the homebound child. Further, because of the limited nature and extent of equipment

and materials which realistically may be taken to the home by the teacher, the quality of education is at risk. For all of these reasons the aim of any homebound program should in the first instance, be to assist that child to return to a school situation as soon as possible. In the case of school phobics the "school situation" would need to be a special therapeutic program.

However, whilst a child is homebound, whether the reason is physical, intellectual or emotional, if he/she is considered medically to be capable of participating in learning activities, an appropriate educational service should be provided.

APPENDIX

A Contribution from Miss R. Shepherd

The intellectually handicapped child may be "homebound" for a variety of reasons :-

1. By reason of the severity of his handicap - for example, the profoundly handicapped child may be immobile or certainly significantly delayed in achieving mobility, he may be physically large while at the same time very dependent in a number of care areas, including feeding, toileting. This will limit his attendance at a conventional training facility and similarly limit his social experiences, such as outings, visits to relatives.

2. By reason of secondary problems, which make him similarly difficult to manage away from home and similarly restrict him to the home - problems such as cerebral palsy, epilepsy, hydrocephalus.

It must be realized that a homebound child means a homebound parent, and increases both the physical and emotional stress on the parents.

The problem may be aggravated by a parent's (usually a mother's) illness, by the presence of young siblings who are also dependent and difficult to take out, or even by a lack of acceptance of the child's handicap and unwillingness to display him to public view. The latter situation is not helped by some public reactions to a significantly handicapped child.

A profoundly handicapped child may be living at home by the parents' preference, or while awaiting admission to a residential care facility. In either case, his continuous presence in the home underlines the need for domiciliary intervention with a view to -

i) making his care at home more comfortable for parent and child, by assisting the parents in handling techniques;

ii) making his care at home more productive in terms of his development; and

iii) minimizing the development of further secondary problems.

A variety of disciplines may be involved in this sort of program - occupational therapists, physiotherapists, psychologists, etc.

However, domiciliary programs should not be revived as a substitute for training programs and social experiences outside the home. In my experience in talking with parents, one of the most wearing problems is the failure of handicapped children to meet the expectations of gradually developing independence, which we all hold with regard to children.

That is, it is reasonable enough to provide most of the child's care and learning experiences within the home setting for the first few years of life, but in our culture we expect the child progressively to move away from the home for increasing periods of time, in the normal cycle of pre-school, school plus additional recreational activities outside the home, and so on.

In the case of a profoundly handicapped child whose care continues to place so much demand on a parent's time and stamina, it seems to me to be even more important to simulate this process and meet this expectation. This underlines the need to consider this group as having some priority in service provision rather than placing them at the bottom of the list.

It is considered that both forms of service provision - i.e. domiciliary intervention and access to programs away from home - should be well integrated.

B. *Contribution from Mrs. J. Norton*

One of the aims of our society is to provide equality of educational opportunity for all students. So in July, 1973, the Queensland Education Department decided that provision should be made for health impaired students, those who for medical reasons including illness or accident are unable to leave their homes to attend school, to receive an educational program in their own home.

The very first pupils of this service were physically incapable of coping with a school situation and indeed were incapable of coping with formal lessons, being children who suffered from muscular dystrophy, brain damage and/or malignancies. Other groups of children who could be provided with home teachers include, and I quote from "The Exceptional Individual" by Telford and Sawtry,

1. physically weak orthopaedically disabled children who cannot attend school because of the difficulties and strains of travel, or for whom transport is unavailable or the building is not suitable;

2. children suffering severe cardiac disorders who cannot attend school but do not require hospitalisation;

3. children whose physical or mental health would be endangered by excitement, infection or injury. (haemophiliacs).

4. children who must remain at home while concurrent psychiatric treatment is provided;

5. children with such frequent and severe uncontrollable seizures that school attendance is inadvisable.

Children visited have included those in full body plaster such as scoliosis suffering, one suffering from intense migraines brought on by the pressure of formal schooling, haemophiliacs, muscular dystrophy and malignancies.

Provision has been made for this service to be extended to another group of children whose education had been worrying members of the State Special School, Royal Children's Hospital, for some time. These are children who are convalescing at home following hospitalization and who had been pupils of this school while in hospital. Their incapacity is relatively short term and includes children with fractured femurs, brain damage, and scoliosis, and burns.

As more doctors are recognising the value of a minimum stay in hospital in alien surroundings and a maximum stay at home convalescing within the emotional security of the patients own home, the greater is the demand for a continuing educational program for these children.

Guidelines for enrolment of the homebound child

1. Provision of a current Medical Certificate stating that the child is physically incapable of attending a normal school.

2. Assessment by a Guidance Officer and/or recommendation of the Principal of the State Special School, Royal Children's Hospital, Brisbane, in consultation with the Regional Guidance Officer. Often pupils are brought to the Education Department's attention by medical staff, social workers, therapists of the various disciplines, principals of the child's previous school, and parents.

3. A parent or guardian must be in attendance at the home during the teacher's visit, for a variety of reasons.

Type of program provided

Obviously the educational program is tailored to the pupil's needs. However for the purpose of discussion it is desirable to divide the pupils into two groups, namely those who are convalescing who would require the service for a limited period of time, and those whose requirements cannot be met by any other educational institution and whose program would be of a more continuing nature.

The short term patient

The school is contacted and a program is sought so that the child may return to school with a minimum disruption to his normal schooling. If the child is to be absent for over five or six months and his school is not very cooperative about supplying the normal school program the pupil is enrolled with the Correspondence School. Many of these children are in Secondary Schools and the Homebound Service has always had most cordial and helpful relations with the Secondary Correspondence School. Thus the visiting teacher is really supplementing programs provided by other schools, usually the child's own.

The long term patients

For these pupils the Homebound Service must provide a special program both informal and flexible as our first consideration and responsibility is the child and his needs. In addition the teacher has a supportive role to play to the parents and in particular to the mother. This is especially necessary in the case of pupils with terminal conditions. The program is geared to the child who is allowed to progress at his own rate. Prerecorded tapes and roneoed sheets for a weekly program are left at each weekly visit and a selection of books from the school library. Occasionally slides or strip films are shown during the teacher's visit. The tapes bring the teacher into close daily contact with the child per medium of the teacher's voice. Our program is of necessity slanted towards the audio visual presentation of lessons.

The lessons take place in the child's home, in the kitchen, the bedroom or the lounge, at a table, by a bed, on the floor, under the rotor bed, in fact wherever it is most comfortable and convenient for the child and his family.

The length of the lesson depends largely on the child's attention span and physical health. Usually a one and a half hour session suits best. How often these visits occur depends on the availability of teachers and so far a once a week service has been provided. Ideally twice a week would be a minimum.

As two disadvantages of education for the homebound are the lack of Teacher/Pupil contact and the loss of stimulation through interaction with his peers these visits would be discontinued if:

1. a student is well enough to return to his own school;
2. a place was found for him in a special school;
3. the program were to jeopardize the child's health.

Thus periodic review must be made in each and every case to ensure that each child is being catered for adequately and that in the case of the short term patient he is returned to his own school withou educational handicap.

> "It should be plain that home instruction is not a pupil personal service; it is not a charity; it is an instructional offering. It is enrichment; it is educational remediation; it is educationally evaluative; it is an educational opportunity; it is the right of all children; it travels to the children wherever they are."
> (Connor, Education of Homebound and Hospitalised Children).

The possibility of a teacher-student telephone link is not beyond the realms of possibility and has been implemented in the U.S.A. In 1972 the P.M.G. issued a report on the telephone as a teaching media. Telecom Communications in Education by G.W.H. Gosling "A report commissioned by the Australian Post Office on uses and planned uses for Australian Educators of Telecommunication facilities could meet a real need in the student community in the future.

C. *Contribution from Mrs P. Johnson*

The Noah's Ark Toy Library for Handicapped Children at New Farm is an existing facility for the homebound child.

What is a Toy Library?

Just as the name implies. A collection of toys, play equipment and related books available for members to borrow. Library membership is open to families of handicapped children, groups and organizations working with handicapped children and members of the public interested in handicapped children.

Aim of Toy Library.

The library provides an extensive collection (2,000 toys at the present time) of toys and play equipment. Some is specially designed, others are adapted and modified.

Guidance is given by the library staff to enable the members to choose toys and equipment appropriate to the child's handicap and developmental stage.

The library is *not* an additional therapy centre, it is a Toy Library. Here toys and play equipment are available for borrowing and experimentation. Advice is given on toys play and play activities. Books are available on all these. The library staff whenever possible works in cooperation with centres for handicapped children throughout Brisbane.

Why Toys?

To an adult play may be a form of recreation and an escape from routine. But to the child play is work. It is through play that the child gains experience necessary for his intellectual, social and physical development.

The child needs to play and toys are his tools of play.

HOWEVER -

We must remember that play comes first, toys follow. We do not play as a result of having toys. Toys are more or less pegs on which to hang our play.

In theory toys are not essential-the child could wander through his fantasy world just using imagination. Toys provide solid and tangible points. Just as language allows for more subtle and complicated thoughts. Toys do the same for play.

The baby's first and best toy is his mother. She can bounce, swing, spin, turn, play peek-a-boo, make noises when touched, feel soft, hard, rough and smooth. But mother cannot always be around and therefore toys can provide play objects independent of mother, e.g. a peek-a-boo mother can be replaced by a mirror or jack-in-the-box.

How do families hear of us?

Families come through various channels. Most are referred through centres in Brisbane dealing with handicapped children, e.g. Spastic Centre, C.A.C., Autistic Centre, Narbethong, W.R. Black Home and many others.

There is no formal referral system. However it is easier for the library staff and the parent if some information is sent with the family.

There are no restrictions on age or handicap. The handicap need not be permanent. We will provide toys to children recovering from accidents or hospitalization, foster children and migrant children.

I feel that if the child is thought to be handicapped he is.

HOW DOES THE LIBRARY OPERATE?

The library is open four days a week and one Saturday a month (see handout).

As there are a large number of members (200 individuals and 40 groups) an appointment is essential for the first visit.

The toys can be borrowed for one month with an extension of one month possible. The membership fee is $2.00 per year, for families $10.00 per year for organizations. There is a hiring fee of 20c per toy,

No charge is made for broken toys however a replacement fee is charged for complete loss. All fees are waived in cases of financial stress.

AT THE MOMENT THE LIBRARY OFFERS -

(a) Toy borrowing facilities in New Farm, Sunnybank, Ipswich and limited facilities to country individuals.

(b) Guidance in toy selection and buying to parents and groups.

(c) A small book library.

(d) Holiday programs.

(e) Advice on establishment of toy libraries throughout Queensland.

The library has recently received a Federal Government Grant. We are looking for ways to expand. Some suggestions have been -

- establishment of regular play sessions at the Library
- family evenings at the library with film, guest speakers, workshops.
- more suburban depots.

WORKING PARTY - GROUP VIII - PROSTHESIS IN EDUCATIONAL INTERVENTION

Group Leader : Mr. S. Stieler,
Acting Principal,
State School for Spastic Children,
New Farm, Brisbane.

Key Persons : Sr. Agostinelli,
Royal Children's Hospital,
Herston Road,
Herston.

Dr. F. Leditschke,
Reader in Child Health,
Herston Road,
Herston.

Miss E. McDonnell,
Xavier School,
Coorparoo.

Sr. Stilman,
Sister in charge of Prosthesis,
Royal Children's Hospital,
Herston Road,
Herston.

Ms. U. Urbacher,
Multicap Meadows,
303 Padstow Road,
Eight Mile Plains.

Chapter 20

PROSTHESIS IN EDUCATIONAL INTERVENTION

A Report from Group VIII

Nothing indicates more the deviant in societies midst, than the person wearing or using some clumsy apparatus ostensibly to allow him to function more normally. It is this feature which was used considerably by charities during the period prior to the present "normalization" philosophy. The public sympathy created to help fund raising, emphasized separation from society. The child wearing calipers or the person with dark glasses or a white cane were popular stereotypes. The modern international access symbol is used to demonstrate the reverse trend that the handicapped should be, and are, normally present in society.

The development of hearing aids, artificial limbs, spectacles and other prostheses, is a somewhat natural extension of mans' tendency to use tools when his own physical proficiency is inadequate. The generally accepted view of prosthesis is in reference to artificial limbs. Our definition is much broader and includes any device or agent that replaces or improves some personal function. The advantage of this definition is twofold.

(i) It places the child with a wheelchair on the same continuum as a person wearing spectacles.

(ii) It recognizes trends, particularly in therapy, which are aimed at providing alternatives to cumbersome attachments.

It is not surprising that a high level of sophistication and practicability characterizes most prostheses in current use. User comfort even over long periods is a feature of modern appliances. Designs are sufficiently versatile to overcome many environmental barriers.

To reach this stage continual development has been required. The helping professions have all been involved in creating and experimenting with appliance designs. Some of the larger handicapped peoples centres have prosthetic departments. Smaller institutions must rely on major hospitals or voluntary support. Brisbane centres are fortunate in having students from the Queensland Institute of Technology to undertake the design and modifications of apparatus as part of their design courses.

It could be argued that as most prostheses require individual fitting and design this ad hoc approach to design is unavoidable and desirable. Also, where appliances such as urinary bags and wheelchairs are capable of being mass produced this occurs. In other words where economies are possible they are attained. It is unwise, however, to

overlook the considerable development work carried out by institutions for the handicapped prior to business firms taking up manufacturing. Often during this stage considerable duplication of effort occurs. In one instance duplication continued right through to commercial manufacture. The concurrent manufacture of "Possum" and "Carba Linguaduc" environmental control systems demonstrates a considerable lack of awareness of developments occurring within the field, and a waste of valuable professional time.

A necessary corollary to the design and manufacture of appliances is the development of programs to teach socially acceptable use. This aspect follows a similar ad hoc pattern in the community to appliance development. Some hospitals, schools and therapy centres have adopted comprehensive roles in helping the handicapped develop independence, an ability to function within existing environments, and personal care. Attempts are also made by these institutions to communicate with parents and others in frequent contact with the handicapped, about the nature and use of appliances.

Often the situation is the reverse. Frequently we find that particular personnel within hospitals and schools are the only ones who understand the use of certain appliances or methods of management. The nurse who learns the proper care of stomal appliances frequently is left to that task. Similarly the teacher who learns sign language is often the only one able to talk to the deaf child.

The major concern of the present is the existence of negative attitudes both within the handicapped and within the community at large. The situation mentioned in the previous paragraph is one example of disturbing attitudes amongst the services caring for the handicapped.

The familiarity that a person has with a particular appliance determines his level of apprehensiveness. Teachers in regular schools often communicate these anxieties to their pupils and damage relationships between the integrated handicapped child and his "normal" peers. Of greater concern is the non accepting school where pupils demonstrate cruel and unhealthy curiosities towards handicapped children.

Present integration policies depend on teacher and school administration acceptance. One attitude recently expressed by a parents and citizens association is that integration is an acceptable policy providing that a disproportionate amount of teacher time is not taken up in management. If this is an indication of general public reaction then handicapped children with problems of this nature both in physical management and in learning skills need increased aide and visiting teacher support.

Where schools are "accepting", different problems occur. There seems to be a reluctance on the part of school officials to contact support services when problems arise, particularly the child's

medical practitioner. A parallel situation exists in the medical profession that where a local general practitioner agrees to treat a handicapped child a reluctance to contact specialist help is often noted.

These problems are no doubt exacerbated by the delays in receiving support. Country children who are integrated, often have to wait for periods of a month or more before a visiting teacher shows up. New problems with prostheses are often generated in this time by mismanagement. The primary principal who insists on a spina bifida child's mother coming to school each day just to empty a urinary appliance is one example of this.

Another area which causes concern with the integration of handicapped children into regular schools is access. Wheelchair access to Queensland schools is extremely limited because of poor design. Works Departments have incorporated requirements for the handicapped in their design policies but new schools are still being built without these facilities. Expense saved in construction is often transmitted to parents who have to travel large distances to suitable schools or Education Departments are expected to meet excess transport costs. Secondary schools are of particular concern. There are only two schools in the metropolitan area which are suitable. One of these was not designed for access but had to have considerable modification done to make it accessible.

While all of these concerns are apparent, the parent of the handicapped child through necessity becomes increasingly involved with the concerns of her child. The result of this is overprotection. A high level of initial counselling of parents is required when prostheses are fitted. Continuing counselling and management training is required of both parent and child to allow them to cope with critical periods in the child's life such as puberty. The present lack of counselling staff leads to difficulties in fostering independence and thus reducing overprotection. A further problem is that present facilities for design of prostheses and training are not well publicized and are perhaps under-utilized by parents.

One group of handicapped is particularly disadvantaged in its use of even the most modern prostheses. The moderately and severely retarded because of difficulties in training and communication find artificial appliances less relevant than do more able children. This means that greater concentration on the broad interpretation of prostheses is required by therapists. A recognition of the value of play in fostering development, particularly in communication and physical skills is required. Therapists working with the multiple handicapped need to take a strong stance in advocating environmental modifications which will avoid the necessity for artificial appliances.

Recent developments in medicine and therapy show a trend away from the "tool" approach to the development of internal control. The Peto system of therapy for cerebral palsied children reported at this conference depends on the development of internal functioning and control

and shuns the use of alternative appliances, e.g. electric typewriters as an alternative to writing skill. Improvements in electronic bladder and sphicter stimulation may make it possible for a proportion of spina bifida children to gain bladder control and not need urinary diversions. The exploration of electronic brain stimulation by the Spastic Centre of New South Wales and the development and bio-feedback techniques are other examples of this trend. The ramifications of these trends are that less cumbersome attachments may be developed and that complete elimination of appliances may be possible in some cases. It must be stressed, however, that these developments are yet to be fully researched and are speculative at this stage.

Recommendations

Communications

The major concern of the group is that people who are responsible for the management of a child often do not know fundamental details of the operation and use of prostheses. Often, children, particularly in the country, are found to be without useful appliances. Recommendations are thus aimed largely at improving communication.

(i) Increases in the number of visiting teachers and itinerant nursing staff particularly in the country are required.

(ii) Medical advisors should be urged to encourage teachers and principals to communicate with them regarding appliance management.

(iii) The publication in pamphlet form of general prostheses management techniques by the State Health Department is required. These pamphlets should make a specific request to school staff to contact children's medical advisors. Visiting teachers and nursing staff could distribute these pamphlets.

(iv) For children not making use of prostheses design services, handicapped children's centres should advertise this aspect of their function.

(v) Education programs of short duration for teachers and nurses should be available in training institutions. These should be available to both pre-service and in-service students.

Therapy

A full range of therapy services is required for multiply handicapped children in Queensland to cater for their inability to use regular prostheses. Other recommendations in this area are -

(i) Emphasis on recreational play is required in therapy programs particularly with the retarded.

(ii) Families require counselling in coping strategies.

Design

(i) The trend towards less cumbersome and greater use of natural functioning should be supported by increased grants for research in this area by the National Health and Medical Research Council.

(ii) Encouragement of communication between design centres to avoid wasteful duplication of effort is needed. This could possibly be achieved through the inclusion of articles on exploratory design in professional newsletters and journals.

(iii) Education departments should undertake a systematic upgrading of access provisions in regular schools so that at least some of the classrooms are available to handicapped children.

WORKSHOP - GROUP IX - HANDLING SKILLS FOR PROMOTING PSYCHOMOTOR DEVELOPMENT

Group Leader : Miss Yvonne Burns,
Lecturer in Physiotherapy,
University of Queensland,
St. Lucia.

Key Persons : Dr. Simon Haskell,
Senior Lecturer - Special Education,
Burwood State College,
Burwood, Vic.

Dr. D. Tudehope,
Director of Neonatology,
Mater Mothers,
Brisbane.

Mrs. Sue Walker,
Speech Therapist at Pre-school for Deaf,
Brisbane.

Mrs. Pauline Watter,
Physiotherapy Department,
University of Queensland,
St. Lucia, Qld. (Part-time)

Miss Barbara Watson,
Occupational Therapist,
Spastic Centre,
Brisbane.

A special contribution from Dr. D. Tudehope is appended.

Chapter 21

HANDLING SKILLS FOR PROMOTING PSYCHOMOTOR DEVELOPMENT

Report from Group IX

The workshop session opened with a brief introduction to promote the theme of the workshop. "Handling Skills" can imply physical handling, emotional handling and also the management of the total child. The group was importantly reminded at the outset, that the child was the central theme of the session and that the key people were really the parents. Influences on parents, as well as on the people concerned with the child, will affect their handling and therefore the psychomotor development of the child. These influences may come from many directions (e.g. educational, social, medical and the health-allied professional areas). This concept reinforced the overriding theme of the whole conference.

Dr. Tudehope chose "outcome of Low Birth Weight Infants" as his topic for this session. He looked at the incidence of low birth weight babies and the neonatal mortality and morbidity rates, with respect to advances in quality of care of this group, over the last decade. Citing relevant figures of incidence averaged from many studies, he showed that an aggressive attitude to management will result in lower mortality of the low birth weight infant group, with perhaps a higher percentage of morbidity amongst survivors, but definitely a higher absolute number of normal babies as an end result. The need for adequate follow-up of such a "high-risk" group was then discussed, both on short term and long-term bases. He concluded that current data has shown steady improvement in the outlook for low birth weight infants, both in survival rate and quality of the survivors.

Mrs. Watter spoke on handling of the child with coordination and other minor motor problems. Children referred to her with these problems usually fell into four main categories, namely those showing evidence of slow development; those children who are notably 'clumsy' having minor neurological problems; those with learning problems and those children who are hyperactive. She then compared these main groups, discussing the basic problems in each area and the manner of the handling of these problems from a physiotherapeutic point of view. Importantly, she reminded the workshop group of the total child, by including other problems that a child may have as a result of his primary problem, e.g. poor ego development, poor development of interpersonal relationships leading to emotional and behavioural problems.

Dr. Haskell's contribution to the workshop centred around the growth of intelligence. Some of the theories of Piaget and Hebb which particularly related to the importance of the environment were emphasized. The need for interaction with the environment, as well as a knowledge of it, was stressed and how the motor aspects of learning were involved with the whole process.

Sue Walker spoke about the interdisciplinary team and how it could be used to enhance the child's ultimate potential. She illustrated this by describing her everyday work situation. Mrs. Walker explained how the team could be structured so that effectively, each member of the team (including the child and parents) is of equal standing and as a result, all team members work and combine together. In this way a common problem found with the team approach, i.e. fragmentation of handling of the child and his parents, is prevented. In the total management of a child, the team works out priorities and then acts together to give the best total program of management for the child and his parent.

"Some Considerations of the Services Given by Occupational Therapists" was the topic Miss Watson selected for this session. She emphasized how one must not work with the child alone, but with him in the context of his environment. In particular, she examined the environments of the physically handicapped and the institutionalized intellectually handicapped, and dramatically illustrated common pitfalls of workers in these areas. She also investigated how the services of the therapists working in these areas could best be delivered, through a variety of roles e.g. specialist clinician, parent-educator, consultant, or coordinator of a host of overlapping services.

Early infant identification of developmental abnormality or dysfunction is not always possible. Although infant development progresses in a fairly predictable, orderly sequence, there is considerable variation within the expected normal range of response. This may be influenced by genetic endowment, internal and external factors. In the light of this, Miss Burns then drew attention to some of the available infant assessment scales and their failure to identify basic developmental problems. The need for neurological, sensory and motor criteria to be included in assessments was then discussed. The identification of the basic areas of dysfunction having been established, the need for parental involvement in the treatment, which should be specific but flexible and functional, was then highlighted.

From the above presentations and the discussions that followed, it became apparent that the group felt that needs were evident principally in two main areas.

Firstly, the need for developmental follow up of particular groups of children, viz: all very low birth weight infants (less than 1,500 gms.), those who have been on a ventilator and those infants who have suffered a crisis which may lead to long term problems. Also, those children who have suffered some condition causing neurological damage or dysfunction, even if at the time, the effect appeared to be transitory. Developmental follow-up requires the services of many professions, not all of which would be involved with each child. However, a basic care team should be organized to provide this and further detailed evaluations should be available as required.

Secondly, the need for a means whereby all children of one family or the family itself, could receive necessary help and advice (i.e. assessment, evaluation, tests and treatment advice) from the one

centre instead of two or three. The establishment of central advisory clinics for the assessment and treatment of some children with developmental problems (particularly those of an apparent minor-motor or perceptual nature) could help fulfil this need.

Other areas of need which became apparent were for assessment and treatment personnel to visit children in their own homes; and for all those working with a child (including the family) to work together in the one program. It was felt that improvements gained by handicapped children from an integrated cooperative team with a high level of personal involvement and specialization, would far outweigh any problems, such as maintenance of continuity of personnel and economics, which may be encountered.

Appendix

GROWTH AND DEVELOPMENT OF LOW BIRTH WEIGHT INFANTS

Contribution by David I. Tudehope

Low Birth Weight (LBW) is defined as <2500 g. Approximately 33% of LBW infants will be small for gestational age (SGA) and 66% appropriate for gestational age prematures (AGA). The outcome for these two groups is quite different and thus it is mandatory to assess G.A., preferably by Dubowitz exam.

Very Low Birth Weight (VLBW) is <1500 g.

Incidence of LBW : USA Collaborative Study : Black 16.6%. White 7.1%. At Mater Mothers' Hospital in 1976, it was 7.0%.

The quality of neonatal care is assessed by mortality rate and morbidity of survivors at follow-up exam.

Neonatal Mortality Rate (NMR)

Survival of VLBW infants has improved markedly over the last 20 years, e.g. at Toronto Hospital for Sick Children the mortality of infants <1500 g. has been:

Before 1960 - 85%, 1960-1970 - 70%, 1970-1972 - 52%, 1973-1974 - 45%, 1975 + - 35%.

Must remember all these babies were outborn and 45% were <1000 g. birth weight.

To fully appreciate the impact of birth weight on NMR, we have to subdivide babies into 250 g. birth weight groups and into 100 g. groups <1000 g. The San Francisco survival data collected between 1970-1976 illustrates this point:

500-600 g. = 20%, 601-700 - 0%, 701-800 - 16%, 801-900 - 8%, 901-1000 - 62%, 1001-1250 - 74%, 1251-1500 - 89%.

Thus overall survival for infants <1500 g. was 65%.

The impact of an *intensive care nursery* (I.C.N.) on NMR can be appreciated by the McMaster University, Hamilton, Ontario, experience. NMR is defined here as deaths within 28 days of life in live born infants <1000 g.

In 1971 (before ICN) - 12.5/1000. In 1972, 1973 (after ICN) - 7.7/1000 amongst 18,000 deliveries in the entire catchment area. Thus 86 babies saved at a cost of about three million dollars.

Growth

The healthy premature who is AGA can be expected to grow at same rate as a term infant of same *post conceptual* age, i.e. regain birth weight at 2 weeks post natal age and then accelerate so that by E.D.C. infant will be near expected weight. At follow-up, Height, Weight and H.C. will be at or just below 50th percentile for post conceptual age.

Growth failure often occurs in SGA and sick prematures who receive inadequate nutrition for first 4-6 weeks. In this later group, linear and head growth virtually cease and even when adequate nutrition is established growth is suboptimal. Similarly, SGA infants have a mean weight between 10th and 25th percentile, at follow-up.

Neonatal Morbidity

Morbidity has fallen pari passu with mortality over recent years.

Medical problems at follow up of VLBW infants, with incidence figures averaged from many studies are:

PULMONARY: Bronchiolitis/Pneumonia
- 10% in survivors of RDS
- 25% in survivors of mechanical ventilation
- 60% in survivors of BPD

Cot Death - (13/1000 versus 3/1000 for full term).

CARDIAC: PDA - 45% of VLBW with RDS but majority close by E.D.C.

OCULAR: Retrolental fibroplasia 1-2%, Myopia and Strabismus are common but no incidence figures available.

HEARING: Sensorineural hearing loss 1-2%.

SURGICAL: Inguinal and umbilical herniae and undescended testes are all common.

Neurological problems at follow up in VLBW infants

MAJOR Neurological Handicaps:

Spastic diplegia 3.5%

Hypotonia, hemiplegia, quadriplegia 2%

Hydrocephalus 4%

Microcephalus 0.5%

MINOR Neurological Handicaps:

Ataxia, incoordination 3.5%

Specific learning difficulties

Minimal cerebral dysfunction.

I.Q. Mean global IQ ranges from 90-97 in reported series.

Follow-up data must be interpreted with knowledge of initial population number, biographical data and % mortality, i.e. an aggressive attitude will result in lower mortality, perhaps a higher percentage of morbidity amongst survivors but definitely a higher absolute number of normal babies as an end result.

Adequate Follow-up

From initial *total* population attrition rate should not exceed 20%.

Duration is uncertain but by 2 years major neurological handicaps are detected, however, learning difficulties, behavioural disturbances and low I.Q. often not detected. Long term follow-up (5-8 years) suffers because neonatal care is so rapidly evolving that management 7 years ago bears little resemblance to current practice.

Do follow-up results identify any groups of infants where treatment should be withheld?

e.g. 1. Resuscitation of infants with perinatal cardiac arrest or severe birth asphyxia.

2. Infants <1000 g. birth weight.

3. Infants requiring ventilation.

These are philosophical questions that require very careful evaluation.

Summary:

The current data available suggest that there has been steady improvement over the last 15 years in the outlook for LBW infants, both in survival rate and quality of survivors.

WORKSHOP - GROUP X - PROBLEMS OF DEAF CHILDREN IN REGULAR SCHOOLS

Group Leader : Mr. S.J. Cliffe,
Senior Guidance Officer,
Physically Handicapped Chilfren,
Brisbane.

Key Persons : Mr. T. King,
Queensland School for the Deaf,
Cornwall Street,
Dutton Park, Qld.

Mrs Kay Ng,
Speech Therapist,
Brisbane.

Mr. W. Tonisson,
Acting Officer-in-charge,
National Acoustic Laboratory,
Brisbane.

Mr. L. Vidler,
Queensland School for the Deaf,
Cornwall Street,
Dutton Park, Qld.

Chapter 22

PROBLEMS OF DEAF CHILDREN IN REGULAR SCHOOLS

Report from Group X

The Queensland scene in the education of hearing impaired children has seen dramatic changes in recent years. Until the 1970's, children whose educational needs were so pressing that they could not remain in the regular school were placed in the Queensland School for the Deaf, Cornwall Street, Brisbane. A small number of children however, were moved from the School for the Deaf to regular schools and assisted by a visiting teacher of the deaf who was a member of the Staff of the Cornwall Street school. In a vast state such as Queensland, country children diagnosed as deaf were required to board in the residential of the School for the Deaf if their parents were unable to move to Brisbane.

The seventies have seen the establishment of centres to provide for hearing impaired children in cities throughout the state. Units have been attached to pre-schools and primary schools with administrative responsibility in the hands of the school principal. Resource centres have also been placed in a number of high schools. A further development has been the extension of a visiting teacher service which has expanded to assist hearing impaired children in Brisbane and country centres. Teachers in the country units operate an intinerant service from the unit to pre-schools, primary and secondary schools. Visiting teachers based in Brisbane endeavour to assist children in other areas with visits to other country areas where this can be arranged. The expansion of support services within the Guidance and Special Education Branch has seen the involvement of speech therapy services for many hearing impaired children in pre-schools and primary schools. Resource/remedial teachers and guidance officers are also available in a supportive role.

The changing role of the School for the Deaf

The role of the School for the Deaf has changed considerably in recent years. Fewer residential children are being placed there particularly at a young age. The availability of special services and support personnel will enable the School for the Deaf to provide intensive programs for severely impaired children. The establishment there of special departments such as media services and educational audiology, envisages the School for the Deaf as a resource centre which can serve the state's far-flung units and services for the hearing impaired. Secondary programs particularly in the pre-vocational areas will continue to be an important focal point at the School for the Deaf. The School has an important role to play in promoting and assisting the entry of deaf students into tertiary and technical levels of education.

Classes for hearing impaired in regular schools

Recent changes in the placement of many hearing impaired children have had considerable implications for teachers in the regular classroom. The establishment of units and resources centres in pre-school, primary and secondary schools has provided a scenario for community-based education for this group. Children attending a unit in Toowoomba, for example, may stay in a private home during the week and return home at the week-end. Often the search for suitable host parents becomes wide ranging and this with the setting up of a special unit has meant a considerable impact on the community. There is no doubt there is a much better understanding of the nature and significance of hearing impairment through the establishment of such a unit in the community. Local newspapers and television stations have featured items of interest relating to the units and have been helpful in such activities as making known the need for local homes to accommodate children who come from places too distant for daily transport to the unit.

Of greater significance however, is the fact that within a number of schools scattered throughout the state there are groups of severely hearing impaired children who are interacting with children in a regular school to varying degrees. For some, because of the severity of handicap, the interaction is minimal, but for others there is considerable involvement with regular classes in a range of subjects. Where this occurs there is close cooperation between the teacher in the regular class and the specialist teacher in the unit. For some children progress may make it possible for the hearing impaired child to move from the highly structured program in the attached unit to a regular school nearer home and be assisted by a visiting teacher.

Early Identification

Experience has shown that early identification of hearing impairment combined with access to support from pre-school units is a vital factor in assisting these children and their parents. The significance of deafness in the development of language and educational progress merits continued pressure on all organizations working with infants and young children to provide early diagnosis.

Early diagnosis will enable intervention procedures at pre-school centres now accessible to most areas in the state to be more effective. While many deaf children will need the services of the School for the Deaf or of the attached unit, the likelihood of increased interaction with the regular class is increased with early diagnosis and consequent intervention.

RECOMMENDATION (1)

Continued efforts must be made to coordinate all agencies involved with young children to provide early diagnosis and promote effective intervention procedures thereby increasing

the opportunities for hearing impaired children to benefit from participation in regular classes.

Hearing impaired children in regular classes

For a number of children with a range of hearing impairment, appropriate placement is in the regular school. The working party saw these children belonging to two groups:

(i) children with a significant sensori-neural loss
(ii) children with a variety of mild hearing problems.

Because of the nature of the handicaps, parents, teachers, and others involved with pre-school children and older students should be alerted to the need for checking any suspicion of a hearing loss, evidenced by speech and language irregularities or attention deficits.

Increased recognition of tell tale signs of hearing loss has resulted in greater use of audiological testing services. Such referrals are continuing to reveal an increasing number of children with mild losses of a sensori-neural or conductive nature.

(i) Children with a significant sensori-neural loss

In line with practice elsewhere, Queensland has integrated a number of children with moderate and severe losses into regular classes, often after help from the School for the Deaf or a pre-school unit for hearing impaired. These children have the necessary communication skills and academic progress for regular class placement. Such placement while considered to be to the child's advantage, needs the back-up of the types of programs which are available in the special classes for the hearing impaired - auditory training and language development programs, for example.

Assistance in concepts found in academic subjects, and individual tutoring are further needs of the hearing impaired child whose alternative placement may be a special class. For these children to receive the advantages of regular class placement, a high level of support on an individual basis is required.

Other children with significant losses may not require the intensive level of support suggested above. They require nevertheless a visiting teacher service on a regular basis with features similar to those mentioned above. Such assistance does not present an adequate picture of the visiting teacher's role - rather it highlights a significant feature of one aspect of the problem. Hearing impairment constitutes such an educational handicap that provision of an adequate visiting teacher service is a critical issue for all hearing impaired children in regular school. Such a service would be able to address itself to assisting individual students and their teachers; and furthermore, develop better understanding of hearing impairment among pupils, parents, staff and community.

RECOMMENDATION (2)

There is need for expansion of the visiting teacher service to provide an adequate support system for all hearing impaired students able to profit from instruction in regular classrooms from pre-school to tertiary level.

(ii) Children with a variety of mild hearing problems

These include conditions involving conductive hearing loss, monaural loss, high frequency loss and mild sensori-neural losses often not assisted by prosthetic devices. The extent and effects of conductive losses among young children have not been realised by educators. Aboriginal children, particularly are prone to this condition with its effect on hearing, attention level and general health.

The working party also discussed the growing concern among teachers that a number of children suspected of being hearing impaired are found to have normal hearing. This group requires further diagnosis, understanding and treatment of auditory processes such as auditory discimination, figure-ground differentiation, short-term auditory memory span and auditory closure. Future developments hopefully will expand techniques and resources to diagnose these aspects of auditory perception.

RECOMMENDATION (3)

The incidence and significance of hearing losses particularly of a mild nature are such that a personalised service to these children and the schools they attend is required.

Hearing impaired children in remote area schools

Earlier in this report, it was stated that development of units in Queensland cities has made special education more accessible to country children. Teachers from these units have been developing a visiting teacher service in their area. However, the vast area of Queensland presents problems in providing a service for hearing impaired children appropriately placed in the regular school but too isolated to be visited from the hearing impaired unit.

RECOMMENDATION (4)

Special procedures need to be involved for hearing impaired children in schools in remote areas.

Coordination of services

Adequate provision of services is dependent on a number of factors. These include the coordination of professional groups and services working with the hearing impaired, the adequacy of trained personnel for the variety of roles involved, the extent of services required to meet the needs of handicapped children with a wide range of needs and scattered throughout a vast state. The working party considered that a coordinating agency would be required to develop a service adequate to the needs of the children concerned.

RECOMMENDATION (5)

The setting up of a coordinating agency with adequate clerical staff should be considered to enable these recommendations to be adopted effectively.

Further recommendations:

RECOMMENDATION (6)

Suitable material to assist teachers in regular schools with hearing impaired children should be developed by a Media Resource Centre with particular emphasis on assisting students, parents and teachers in areas without access to visiting teachers.

RECOMMENDATION (7)

The increased availability of counselling services for hearing impaired children and their parents would assist these children further in coping with problems that occur in the regular school.

WORKSHOP - GROUP XI - TEACHING CHILDREN IN HOSPITAL

Group Leader : Miss Joan K. Atkinson,
Senior Tutor,
Schonell Educational Research Centre,
St. Lucia, Qld.

Key Persons : Dr. P. De Buse,
Acting Director, Intensive Care Unit,
Royal Children's Hospital,
Brisbane.

Mrs Dommett,
Teacher,
Mater Children's Hospital Pre-school,
Brisbane.

Mrs G. Hunt,
Teacher,
Royal Children's Hospital,
Brisbane.

Miss H. McDonald,
Principal,
Royal Children's Hospital School,
Brisbane.

Mrs. L. McLaren,
Teacher,
Opportunity School,
Bundaberg.

Miss D. Matthews,
Physiotherapist,
Royal Children's Hospital,
Brisbane.

Chapter 23

TEACHING CHILDREN IN HOSPITAL

Report from Group XI

Discussion was stimulated in a number of areas with a view to isolating problems and making appropriate recommendations.

RATIONALE : Who do we teach in hospital?
: Why do we teach them?

Miss McDonald, Principal, Royal Brisbane Children's Hospital gave a brief account of the development of hospital schools in Australia from the early years of this century. Childhood diseases of that period resulted in long-term hospitalization (poliomyelitis, diphtheria). Originally hospital schools were founded to provide education for these long-term patients.

Miss McDonald offered participants a copy of a statement of aims she had drawn up concerning the present aims of Royal Children's Hospital School (See Appendix A).

Discussion Area (1) - *Meeting the needs of hospitalized children of all age groups (with widely varying medical and psychological conditions) from pre-school to secondary levels, for greatly varying periods of stay.*

Key persons pointed out that, because of changes in medical techniques, the period of stay in a children's hospital now varied greatly from long-term (couple of months) to what are colloquially known as "quickies" (day patients). Conditions too, vary greatly through surgical, orthopaedic, psychiatric, medical etc.

It was pointed out that there are two rather polarized groups amongst patients in the children's hospital. There are those children whose severity of injury (particularly, brain stem) render it impossible for them to participate in any formal schooling. Their immediate needs, of course, are met more appropriately by occupational therapy, physiotherapy, and speech therapy. On the other hand, there are the increasing numbers of children who are treated as out-patients.

The teachers from the hospital school detailed the kinds of children who tended to come to their attention. They ranged from those whose stay was long-term, a couple of months, middle-term patients who would stay for a lesser period and those whose stay amounted to days only. This, of course, was in addition to those who were in just for tests - the "quickies". Their range was paralleled by a range in grade and ability levels. Grades extended from pre-school to secondary.

Discussion Area (2) - *Admittance to hospital schools and subsequent Attendance.*

Referral procedures vary from hospital to hospital. Royal Brisbane Children's Hospital referral procedures were stated. Hospital school teachers emphasized that they were keen to be involved with all children who could possibly attend school. However referral sometimes appears to be haphazard and tends to depend upon the views of particular ward personnel on the need for schooling.

It was agreed that doctors should recognize the value of hospital schooling when making recommendations concerning a child. The experience of one participating teacher was that most doctors and nurses expected every child to take part in school activities whenever possible.

The teachers agreed that the most vital aspect of referral of a child to the hospital school is that full, relevant information accompany the child. A situation in which a nurse "passed over" a child without providing appropriate referral forms and other relevant information was found to be unsatisfactory. It was also advocated that a team meeting be held once a week.

It was suggested that better liaison between hospital and school personnel could be arrived at, if the referral to the hospital school was automatically implicit in the admission. After all, it is a matter of law that a child attend school.

School admissions and attendance are sometimes adversely affected by lack of communication between medical and school staffs. It was pointed out that the Mater Hospital, Brisbane was more compact than the Royal Children's and thus did not share some of the communication problems. Teachers at the latter institution are concerned about erratic attendances at school. The principal indicated that she has made a submission to hospital authorities concerning this problem.

Dr. De Buse pointed out that, as a doctor, he preferred doctors to see children involved in "normal" activities when making rounds. Therefore, he saw advantage in as many children as possible attending the hospital school regularly and again where possible rounds being made in the school areas rather than in the wards. This procedure could dramatically reduce erratic school attendance at the school due to ward round hold-ups.

In the new school space, facilities existed to allow therapy treatment to be given during school attendance. This could further reduce poor school attendance.

Discussion Area (3) - *Maintaining liaison and communication between doctor/hospital/therapists, teachers/parents and the regular school.*

The question of liaison was seen to be vital to a hospitalized child's needs and involved many people: doctor, therapist, principal and teachers (Hospital School and Regular Schools) and parents. In relation to liaison with schools from which these children came, it was suggested that counsellors and social workers be readily available.

A suggestion was made that a full-time social worker be specifically attached to the hospital school. However, it was pointed out that as the school was part of the hospital, this was the province of the hospital social workers, who were more than willing to be involved providing of course they received a referral.

Liaison with the physiotherapists was then considered. One therapist referred to difficulty in handling numbers requiring aid - sometimes three children at a time. Good cooperation was seen to exist between the physiotherapy section and the hospital school particularly in relation to scheduling. In addition, the physiotherapists frequently take school work down with children to their department so that children may continue to do school work whilst the therapist is attending to other patients. Though it was considered important to have some facilities for physiotherapy within the school section, it was also considered to be important to get some children out and moving - for example, asthmatics. There was general agreement that liaison between professionals is limited and that better communication between all those people concerned with the hospitalized child was crucial.

At this point, it was agreed that the main theme of the workshop seemed to be the importance of communication.

Involvement of parents whilst the child was hospitalized and after discharge was seen as important in helping the parent to understand their children's problems and how to cope with them. The importance of the parent as an intermediatory when the child returned to regular school was emphasized.

Discussion Area (4) - *Difficulties in catering for the widely different demands and needs of short and long-term patients.*

A problem always facing hospital teachers is that of meeting the needs of long-term and short-term patients. A participant based at an inter-state hospital school described the referral procedure at her school whereby children are referred to the school only if they are admitted for periods beyond a fortnight. It was pointed out that a Committee has been set up in New South Wales to investigate the needs of the short-term patient.

The organizational difficulties of dealing with long and short term patients were pursued. It was suggested that individual teachers might specialize in either long or short term patients. Certain points were noted:

- ward support by a teacher over five wards was unrealistic and made for ineffectual organization
- a system established at the Mater resulted in class teachers taking short term patients and ward teachers taking long term patients
- teachers at the Mater described the programs offered by the class teacher as highly individualized
- young children could be offered "group activities" rather than a formal educational program though it was still possible to assess them (Mater teachers indicated cooperation of occupational therapists in this regard).

Discussion Area (5) - *Special educational provisions for specific categories of children receiving hospital treatment.*

(a) Children who are homebound because of illness.
The needs of homebound children are met by a service from the Royal Children's Hospital whereby teachers visit the homes of children who cannot attend school because of medical conditions. It was added that correspondence lessons are not necessarily suitable for such children. The visiting hospital teacher promotes greater involvement. Children temporarily homebound after hospitalization benefit from the visiting service. (See Appendix B).

(b) Children making out-patient visits to the children's hospital
casual out-patients are frequently identified as being "at risk" children who do not attend school regularly in any event. A suggestion was made that some informal program be set up to meet their needs during their visits to the hospital. A room situated adjacent to out-patients section would probably be more suitable than attempting to provide the service in the hospital-school proper.

(c) Short-term (3-5 days) admission.
Reference was made to a rather different group of out-patient children who attend the hospital for regular therapy (and sometimes regular admission). Such children might benefit from enrolment in the hospital school until therapy ceased.

In relation to the above children, it was proposed that different learning environments be structured. A short-term stay (3-5 days) does not offer any real opportunity for educational programs of any great value. Support of such children could well be reviewed. Out-patients could be served by a play therapy type facility. Reference was made to this type of personnel being available in major hospitals in New South Wales.

Discussion Area (6) - *Educational Assessment of hospitalized children.*

In this area, the hospital teachers were seen to operate in a similar fashion to those in regular schools. They needed to ascertain -

- what educational program was needed
- what specific strategies and materials were indicated
- what difficulties a child was experiencing so that remediation could be initiated if necessary.

The point was made that for some children a period in hospital might mean an opportunity for them to receive individual attention for their specific educational problems. The group agreed that many learning problems could be related to frequent absences from school. In this regard, a child with some chronic illness could be seen as vulnerable.

With increased numbers of shorter term patients, hospital teachers are faced with the task of making speedy assessment of performance and attainment levels in order to initiate a program. Hospital teachers have limited time in which to make an assessment of short-term patients' educational needs. In the case of the very short term patient, the teachers agreed assessment frequently amounted to "playing it by ear".

Hospital teachers require a variety of measures and strategies to ascertaining children's educational needs and to initiate suitable action as soon as possible.

The question arose concerning the value of contact with a child's regular teacher as obviously any information from that source would be vital, particularly in the case of short-term patients. However, it was agreed by the hospital teachers, that, at present, few opportunities presented for actual contact with teachers outside the hospital.

The teachers indicated that guidance officers are available to these schools so that children with severe educational problems can be referred to psycho-educational assessment.

A question was asked of hospital teachers :

"What kind of assessment do you use to find a starting point for a child's problem?"

The answer given by a Mater Hospital school teacher indicated that initially she used material from the child's grade level. Failure to cope with that work indicated need for a lower difficulty level. This was true of short term patients. However, it was pointed out, in the case of long-term patients, more opportunity was available to obtain information from the child's regular school. This last procedure was often related to the amount of parent contact and cooperation available. Strong emphasis was given to the needs of secondary students to maintain level of school performance.

Discussion Area (7) - *Management of children being treated for emotional disturbance.*

Special attention was given to the problems dealing with the increasing numbers of hospitalized emotionally disturbed children. The teachers commented that such children tend to be disruptive when working in a group and that the hospital physical environment generally did not lend itself to management of these children.

It was emphasized that the teachers were fully aware of their responsibilities to such children and were concerned to arrive at appropriate management strategies.

The group agreed that the problem was particularly pressing as children admitted to hospital for psychiatric treatment were likely to be extremely disturbed.

The question arose as to how much information and support teachers received from the psychiatric unit at the hospital. The teachers agreed that the degree of support varied. The occasions upon which doctors contacted the teachers and discussed referred children were found to be most helpful.

A number of ideas which might generally improve the situation were put forward -

- teacher/pupil ratio could be reconsidered in dealing with such children
- where possible, these children could be grouped together so that their disruptive behaviour does not disturb other children
- teacher-aides with special training could be available to help with these children.

Discussion Area (8) - *Compiling "at risk" registers from children's hospitals' patient population.*

It was suggested that children who were generally "at risk" would number largely amongst those presenting at children's hospitals. A further suggestion was made that such hospitals would constitute, in a sense, a living "at risk" register. Thus, problems relating to education could be picked up and referred to appropriate support services.

Discussion Area (9) - *Helping children adjust to hospitalization*

Suggestions were made concerning strategies to help children to adjust to hospitalization. The following were put forward -

- role playing in the context of drama therapy was advocated so that children could cope with emotional stresses

- the work of Mrs. Lovelace at Stanford University was recommended as a reference in this area
- a pre-hospitalization program was advocated.

Discussion Area (10) - *The role of parents in relation to hospital schools.*

The question was raised concerning involvement of parents in hospital schools. In general, it was agreed that parental assistance and involvement was welcomed. The following were presented as examples:

- parent can sit in with child as he/she works
- parent is welcome to consult with teacher on child's needs and problems
- the school can function as an observation post where parent, child interaction can be assessed.

The comment was made that the last mentioned function could also be considered for out-patients.

Discussion Area (11) - *Requirements necessary for teachers wishing to work as hospital teachers.* (See Appendix C).

The requirements for hospital teaching were considered under the headings of attributes and training. The group agreed on the following:

- experienced teachers are required with a deal of practical experience
- a large measure of emotional stability is required
- background in special education is necessary to cope with special needs in children
- wide experience in as many areas as possible is helpful in dealing with the wide range of children in hospital
- access to in-service training is necessary to permit teachers to keep in contact with regular school practices
- variety of problems encountered requires teachers with specialist qualifications.

However, the particular problems experienced in hospital schools would seem to call for the following additional requirements:

- pupil/teacher ratio needs to be reconsidered
- supply teachers need to be made available
- support teachers are needed for special purposes.

Present course requirements for training of hospital teachers in Queensland were discussed. Teachers presently undertake the course for Teachers of the Physically Handicapped at Mt. Gravatt College. The group considered that, in light of the demands made of hospital teachers, a course which trains Resource Teachers could be more suitable. These teachers were considered to be generalists in special education and this was felt to accord with the tasks of the hospital teachers.

The role of the hospital school was seen to have changed markedly in the last three or four years with an increasing number of disturbed children requiring attention. Therefore, the group suggested that consequent developments be considered in relation to facilities and personnel. Withdrawal rooms, for example, should be available in the hospital school to provide for disturbed children. Personnel is also needed to cope with problems arising from increasing numbers of children from differing backgrounds.

In conclusion the group made the following recommendations:

- all children coming into hospital should receive some kind of educational support
- attendance at the hospital school should be automatic for all school-age patients (providing they are well enough) rather than the present practice of admittance on request of the ward doctor
- provisions for long and short term patients need to be reviewed as well as for those regularly attending out-patients and those who are hospitalized for regular periods
- a homebound program should be offered to children temporarily homebound after hospitalization
- teacher/pupil ratios need to be improved and some emphasis should be placed on the provision of specialist teachers and aides
- provision should be made for more appropriate post-graduate, in-service training courses which would better equip staff to deal with the wide variety of problems found in the hospital population
- opportunities for improved and increased communication with other hospital staff are needed so that they may be made aware of what goes on in the hospital school. Student nurses could spend some time working within the hospital school.
- much medical observation and assessment should be carried out within the school setting
- better communication between medical staff (both doctors and nurses), hospital school teachers and therapists, parents and the regular school teacher is crucial to the educational well-being of the hospitalized child.

The Group leader makes acknowledgement to Miss M. Hutchinson for taking notes during reporting.

Appendix A

AIMS OF THE ROYAL CHILDREN'S HOSPITAL SCHOOL

Contribution by Heather McDonald

The Hospital School seeks :

(a) to provide education in its fullest sense, commensurate with the ability and condition of the child;

(b) to encourage the child to adjust to his surroundings, to accept his present circumstances and endeavour to cope with immediate physical and/or medical condition;

(c) to offer a stimulating environment, amid familiar school books and equipment and thus give re-assurance to the hospitalized child and so help to alleviate homesickness, boredom and anxiety, and, by enabling him to become a member of the school group, combat any feeling of isolation that may accrue;

(d) to cooperate with the members of the various disciplines so that the best may be done for the child. (e.g. Provision of rehabilitation programs for accident victims, e.g. brain stem damage, etc.);

(e) to maintain continuity of lessons and thus keep the child abreast of his current school work, so that he need not suffer additional handicap as a result of being in hospital. Hospital schooling has a very definite psychotherapeutic boosting power for the child who may otherwise become severely retarded in his scholastic progress because of prolonged hospitalization;

(f) to provide educational and psychological assessments during his stay in hospital for the child who is failing in his school work. (There are obvious advantages, e.g. new environment, fewer pressures, etc., for having the child assessed while in hospital. This type of child frequently presents at the hospital with psychosomatic symptoms e.g. tummy and headache, but basic cause is his inability to cope with the formal school program. Following testing, it has been possible to facilitate the placement of these children in schools more appropriate to their requirements);

(g) to initiate remedial programs as required by individual patients.

(h) to offer a supportive role to both patient and parents, especially in the cases where prognosis indicates a limited life. It is important that teachers continue to maintain regular contact with such children, proceed normally, and give assurance.

(i) to avoid the development of a dependency syndrome of children undergoing prolonged treatment.

If these objects are attained, the child will return to his home, school and community life, well adjusted physically, mentally and socially to continue his learning processes without further handicap or frustration.

Appendix B

GUIDELINES : VISITING TEACHER SERVICE

Contribution by Heather McDonald

Aims of visiting teacher service to physically handicapped children

i. To provide an educational program or supplement one already provided for a child during period he is unable, because of illness or physical handicap, to attend regular school.

This program should be seen in most cases as a temporary and expedient measure to keep child abreast of school work until he can return to regular school.

The ultimate aim of this service must be to return the child to his school without educational handicap.

ii. To provide special program for children whose requirements cannot be met by other areas presently available.

It is envisaged that the program provided under (i) would be relatively limited, while that provided under (ii) would be of a more continuing nature.

Eligibility for visiting teacher service

i. Children convalescing at home following hospitalization and who are not eligible for correspondence lessons because of short term incapacity e.g. accident cases, including fractured femurs, scoliosis, etc.

ii. Children too health impaired to attend regular or special school.

iii. Orthopaedically disabled children who cannot attend school because of difficulties and strains of travel, or for whom transport is unavailable or the building unsuitable.

iv. Children suffering severe cardiac disorders who cannot attend school but do not require hospitalization.

v. Children whose physical or mental health would be endangered by excitement, infections or injuries.

vi. Children with such frequent and severe uncontrollable epileptic seizures that school attendance is inadvisable.

vii. Children unable to manage the prepared Correspondence Course because of handicap.

Periodic review must be made of each case to ensure that each child is being adequately catered for.

As two of the disadvantages of educating children at home are:-

i. lack of teacher/pupil contact; and
ii. loss of stimulation through lack of contact with other children,

every effort must be made to return the child to the normal stream as soon as possible.

These visits would be discontinued if -

i. a student is well enough to return to his regular school;
ii. a place is found for him in a suitable special school;
iii. the program were to jeopardise the child's health;
iv. the child fails to respond or cooperate.

Required procedure for enrolment of child. For visiting teacher service

i. Provision of a current Medical Certificate.

ii. Assessment by Guidance Officer and/or recommendation of Principal of the State Special School, Royal Children's Hospital, Brisbane, in consultation with Regional Guidance Officer.

Parents' responsibility

Parent or guardian should be in attendance at the home during the teacher's visit so that he/she is aware of the program and its requirements and is thus able to offer continuing encouragement, between the teacher's visits, as well as to attend to any personal needs of the child that may arise during the teacher's visit.

This is an additional safeguard for both teacher and child.

Recommendations

On discharge from hospital a child who has been receiving lessons during his period of hospitalisation (e.g. scoliosis, fractured femur, etc.), and who is unable to return to his regular school, should receive immediate help from a visiting teacher.

Immediate assistance could be provided as follows :-

i. Preferably a program could be provided by the child's own school, as it is hoped the child will return to take his place in his own group.

(This program may be obtained during the child's stay in hospital, as has been the policy in many cases. This is most desirable, especially at the Secondary level, where a continuing program is most essential. This program would be supplemented by visits from the Visiting Teachers Service.)

ii. Program provided by the Hospital School.

Information for Guidance

Fractured Femurs : Usually in traction for 6-8 weeks. Temporarily discharged but in spice plaster and unable to sit; therefore must either stand or lie, for period of 6-8 weeks. Then, if no complications, plaster is removed and the child is usually able to attend regular school.

If there are complications, the child may have to return to hospital for further surgery, followed by another period in a plaster cast.

Scoliosis : Major surgical procedure.
Patient is in hospital for a period of 6-8 weeks initially. Usually in traction. (May vary according to severity of individual condition.)

May return home in full non-walking body plaster cast for a period of approximately 8 weeks.

In hospital again for review and change of plaster for two or three weeks.

If treatment has been successful patient may return home in walking plaster. If school is accessible he may be able to return at this stage, but may require special assistance, e.g. couch to rest on during lunch hour.

If further treatment is required patient will either be hospitalised or return home again in a non-walking plaster. This treatment may extend over a period from 6 months to 2 years.

Appendix C

REQUIREMENTS FOR TEACHERS IN A HOSPITAL

Contribution by Heather McDonald

(i) Enthusiasm and dedication for a difficult job.

(ii) Knowledge of 'normal' child - its developmental and emotional stages and ability to assess child.

(iii) Experienced teacher, preferably one who has had experience in a small school and/or with multiple grades, or in another area of special education.

(iv) Ability to cope with any grade or willingness to qualify in this area, i.e. familiarity with curriculum in primary school.

(v) Ability to assess a child's academic level, especially the child who is experiencing difficulty with formal lessons and provide suitable learning material at the appropriate level. A knowledge of diagnostic and remedial techniques an advantage.

(vi) Ability to assess quickly and to cope with situations as presented by behaviour problems, emotionally disturbed children, those finding difficulty in adjusting to hospital routine, etc. Because of the increasing incidence of children with behaviour problems and emotional disturbances, it is becoming necessary for all teachers to have had some training in these areas.

(vii) Ability to accept varying types of illnesses.

(viii) An awareness and sympathetic understanding of the physical limitations of some medical conditions, without becoming physically or emotionally upset.

(ix) Willingness to accept the transitory nature of most of the school population, yet not become complacent.

(x) Disposition to be able to work harmoniously with those of differing disciplines.

(xi) Willingness to serve in any area, as circumstances dictate, i.e. flexibility and versatility a must.

(xii) Familiarity with teaching resource material, library books and audio-visual materials currently available within the school.

(xiii) Other requirements include :-

1. Patience
2. Common sense
3. Sense of humour
4. Objectivity
5. Good Health

WORKSHOP - GROUP XII - THE ROLE OF THE PSYCHOLOGIST IN MEETING THE NEEDS OF CHILDREN

Group Leader : Mrs Heather Mohay,
Lecturer in Medical Psychology,
University of Queensland,
St. Lucia.

Key Persons : Mrs R. Barnett,
Psychologist,
Royal Children's Hospital,
Brisbane.

Mr. A. Bougoure,
District Guidance Officer,
Brisbane West.

Mr. T Robinson,
Psychologist,
Children's Services,
Brisbane.

Mrs J. Ward,
Guidance Counsellor,
Brisbane.

Chapter 24

THE ROLE OF THE PSYCHOLOGIST IN MEETING THE NEEDS OF CHILDREN

Report from Group XII

It is obvious that there is increasing overlap in the roles played by the different helping professsions. This undoubtedly has many advantages and hopefully aids communication across disciplines. However, it also frequently leads to considerable confusion. It is often difficult to know to whom a child should be referred, and parents frequently become bewildered by the number and diversity of different professions to whom their child is referred. Not uncommonly these professions are duplicating functions and this can cause considerable frustration and annoyance for both the professionals and the parents. If resources and skills are to be used efficiently, it is essential that such duplications be avoided.

Another important factor which requires consideration is that all professions are evolving - up-dating techniques and developing new techniques which permit them to offer new and improved services. Frequently one profession is not aware of the developments taking place in another profession and consequently fail to revise referral requests. For example, psychologists have traditionally been regarded as the administrators of IQ tests, and although nowadays the skills of the psychologist go far beyond this, the most common referral is still "IQ please". Whilst this may be all that is required in some instances, in most cases the child would benefit from a very much more thorough psychological examination or possibly from therapy. If appropriate referrals are not made the skills of the psychologist are not fully utilized.

Interdisciplinary meetings are therefore essential if we are to mobilize the skills available amongst the different professional groups, to the greatest benefit of the child. We are grateful for the opportunity to present some of the ways in which we feel that psychologists can meet the needs of children. We have arranged these under three headings:

(A) Diagnostic Testing

(B) Parent Intervention

(C) Therapy

A. Diagnostic Testing

(i) *Assessment of Children with Minimal Cerebral Dysfunction*

These children frequently do not show any demonstrable neurological disabilities and are often of average or above average intelligence. However they have significant problems in coping with school work and may have severe reading disabilities. On psychological tests they frequently demonstrate difficulties in the processing of visual and or auditory information.

(ii) *Personality Assessment*

There are basically two types of test used for personality assessment. These are (1) questionnaires (2) projective tests. The results of these tests can be extremely useful in assessing an emotionally disturbed child and are invaluable in guiding later therapy, whether this be conducted by the psychologist, social worker or doctor. In general however, all diagnostic assessments require verification by observation of the child in his normal environment.

B. Parent Intervention

When children show disturbed behaviour, a breakdown in communication within the family, or parental mismanagement of the child is frequently apparent. In parent intervention, a systematic attempt is made to make parents more aware of the consequences of their behaviour and to give them greater insight and understanding of their children. Attempts are also made to improve communication skills.

C. Therapy

(i) *Play Therapy*

"Play is the work of childhood" and it is through play that the child advances to new stages in the mastery of his environment. It is also an autotherapeutic process, and when the child is allowed to play in a permissive accepting atmosphere, he is frequently able "to play through" many of his anxieties and find appropriate ways of coping with them.

(ii) *Behaviour Modification*

This technique is based on Learning Theory, and uses rewards, withholding of rewards and in some cases punishment, to establish appropriate behaviour and extinguish inappropriate behaviour. These techniques have been used in a wide range of situations, e.g. toilet

training severely retarded children, teaching speech to autistic children, and improving the writing of children with Minimal Brain Dysfunction. They have also been applied in group situations, e.g. the maintenance of classroom discipline.

Conclusions

It can be seen that the psychologist has many skills to offer in meeting the needs of children. The workshop generally felt that there was insufficient awareness of the services available, and that these services require wider publicity so that more children could benefit.

SECTION THREE

SUMMARY

CHAPTER 25

PERSPECTIVES FOR THE FUTURE : AN EDUCATIONAL VIEWPOINT

Geoffrey Swan

No longer are schools regarded as the only learning place for children and the exclusive working place for teachers. It is now acknowledged that much more learning takes place before a child enters school and there are many educative agencies besides the school. The teacher may have been the sole professional occupant of the classroom once, but this can no longer be the case, for other professions, many of them of recent origin, have much to offer the children - not only in the classroom setting, but in other settings as well.

When Alexander Graham Bell first used the term "special education" in 1898, he was not thinking of a process removed from the mainstream of education; indeed, I regard his statement as the first plea for integration:

> *All that I have said in relation to the deaf would be equally advantageous to the blind and to the feeble-minded. We have in the public school system a large body of ordinary children in the same community. We have there children who cannot hear sufficiently well to profit by instruction in the public schools, and we have children who cannot see sufficiently well to profit by instruction in the public schools, and we have children who are undoubtedly backward in their mental development. Why shouldn't these children form an annex to the public school system, receiving special instruction from special teachers, who shall be able to give instruction to little children who are either deaf, blind, or mentally deficient, without sending them away from their homes or from the ordinary companions with whom they are associated?*

The developments in special education over the last decade have benefited many children with special needs but the associated research, techniques and materials that have been produced have had considerable effect on the education of all children. It has been said that special education has a pilot role and as a result of our concern for children with very specific problems, our knowledge of the learning process of all children has been enhanced.

This seminar, "Health, Education and Welfare", has been a lively one. There have been many differences of opinion and much discussion, but the signal I see most clearly is:

The criterion for all decisions must be the needs of the child.

Most of us work in facilities with various professional groups. This week we have mixed freely and happily with administrators, guidance officers, lawyers, medical practitioners, nurses, occupational therapists, physiotherapists, psychologists, social workers and teachers. Sometimes there was a language barrier, even though everybody spoke English (or varieties of it!). Professional jargon was one inhibitor, but this was readily translated, and no one was disturbed by the question: "Could you explain please?"

Credibility amongst our colleagues in our own and in other professions, can only come as a result of our being most competent in our own areas, combined with a readiness to discuss, be challenged, and sometimes to change our minds. No one profession has all the answers to the problems presented by handicapping conditions.

The future depends on the here and the now. The caring professions cannot work in isolation. The variety of skills required come from a variety of professions, and there is no exclusive territory. In the past the so-called team approach has led to what has been termed "fragmentation of the ego", the child has been seen as an education problem, a physiotherapy problem, a speech problem, and so on. Let us from today focus positively on the child and his strengths, rather than break them up into areas of weakness.

Let us, too, think about our own personal relationships forgetting that unity only comes when everybody agrees with oneself, but remembering that honesty and good manners are essential and basic attributes for all successful working relationships.

CHAPTER 26

PERSPECTIVES FOR THE FUTURE : A MEDICAL VIEWPOINT

Simon Latham

> "Good health within a community cannot be achieved by the provision of even the most comprehensive and generously funded curative medical service. Health depends on very much more than the ready availability of remedies. The physical well-being of a nation is heavily dependent upon its social pattern and way of life" (Gould, 1977).

This interdependence of Health, Education and Welfare has meant that workers in any of these fields must have a working knowledge of the relative disciplines if they are to work effectively and economically.

Unfortunately the knowledge that we have allows us only a superficial understanding of a child's development. Relatively little is known about the intricate interactions between the individual, his inheritance and his upbringing, and the social and physical environment in which he lives. Inheritance patterns determine a child's potential, but this potential can be limited both by physical and social factors. Disease during pregnancy, accidents during child-birth, illness and malnutrition are all limiting factors and generally the earlier they occur the more profound their effects. This potential can also be limited by our social and educational environment. Conversely a child's potential can be increased by a favourable environment. Research and new methods in education have shown us that it is possible to develop a much greater pool of ability in a population than was hitherto believed (W.H.O. Conference, 1974).

In spite of this vision, our social services are consuming an ever increasing slice of the gross national product, and neither medicine nor education are achieving even a fraction of what seems possible. What is fundamentally wrong in our society that allows such an unfavourable environment? Three major issues seem to be involved. These are the physical and social fabrics, and, within these, the family. If the first two of these are compared with the society of Classical Greece some conclusions are possible.

The model of civilisation in classical Greece depended on a physical home for that community; for by shaping his environment, man shapes himself. The heart of Athenian society was the Agora. This was an open space in the heart of every Greek city of 500 B.C., partly

surrounded by colonnades and containing markets, temples, offices, monuments, shops, exchanges, fountains, council chambers, law courts, and amenities of all kinds. The 8-acre Athenian Agora was the cradle of western civilisation, her literature, her arts, her philosophy and her democracy. There is no exact modern equivalent; for the Agora was far more than a civic centre, a market place, a meeting place, a cultural centre, or public place, though it combined all of these. It was a place where the Greeks drifted to find congenial company to gossip, or to relax. Originally it was here that the Greeks went for sport or for cultural life. It was here that they went to shop or to engage in other commercial activity, to have their hair cut or to engage in repartee with Socrates. And it was to the Agora that they went to worship, to take part in the administration of justice, to engage in politics and to assist personally in the affairs of the entire city state. The Agora was in short the pulsating heart of the classical Greek city. It was the most essential feature of that city. Without an Agora, a Greek city simply could not be a Greek city. This seems the first fundamental - that no primary community can exist without a physical home for that community (Peck, 1970).

The Greek citizen of 500 B.C. was favoured in being able to participate actively in the running of his society, unlike the inhabitant of today's modern city. This is in part a failure of planning. Every lonely old age pensioner, every girl who stays shut up in her flat for the whole week-end, every person who cannot pass the skill barrier at the local tennis club and is unable to play a game he dearly wishes to play is a failure on the part of the town planner and contributes not (as he or she could in an efficient town) to human happiness, but to the sum of human misery.

The size of towns or suburbs seems to be a second fundamental. Aristotle writes that Hippodamus planned a city for 10,000 and Plato in the laws suggests 5000 citizens as the ideal figure. Many modern planners are of the opinion that a planned neighbourhood should house between 5,000 and 10,000 people.

Experts will declare that these concepts contain nothing new, but I put them forward as areas in which all our disciplines should be involved. If we are to face our tasks with vision and with aims greater than plugging up individual holes in a dyke, we must look for the means of creating the modern equivalent of the Agora in the suburbs of our towns. To achieve this we must work with the planners and politicians, our disciplines must cross fertilize, and we need to extend into those areas where there is a contribution to be made.

The third fundamental is the family. The history of our own state demonstrates an encouraging awareness of its role and a return from emphasis on institutional care to increasing support of the family structure. There is nevertheless an increasing rate of change in our social and environmental conditions under which the family exists, and this affects the health of all its members. Problems of

social adaptation are created and are reflected in the increasing disturbances of children. We therefore need to be reviewing continually our traditional approaches. It seems to be here that our three disciplines of health, education and welfare need to be most closely integrated. If I can end with a quotation from Professor Bronfenbrenner (1974) of Cornell University:

> "The family is the most humane, effective and economical system of child care known to man. The first aim should be to strengthen the family and enable the parents to function as parents for their children."

References

Dr. Donald Gould. *The New Scientist.* 7th April, 1977.

New Trends in Maternal and Child Health. W.H.O. Conference, Moscow, November, 1974.

Agora. AJA Peck. Amalgamated Press. 1970.

Aristotle. Politics, ii. 5.2.

Bronfenbrenner, U. *A Report on Longitudinal Evaluations of Pre-School Programs.* Washington DC: Department of Health, Education and Welfare, 1974.

CHAPTER 27

THE HEALTH, EDUCATION AND WELFARE OF CHILDREN : AN OVERVIEW

R.J. Andrews and K.J. Cochrane

"I think it is salutory to remind ourselves from time to time that our various professions have not been around all that long. Relative to our long history, the broad mass of people has had free access to schools, health and social welfare agencies for only a brief period....the family system, rather than the individual isolated child should be the prime focus of services" (*David Mitchell, Keynote Address*)

"....there exists a firm base in community attitudes....for all disciplines, systems and community agencies to promote and realise positive goals for the handicapped....in the long run it will be efficient service delivery which determines the quality of life for the exceptional child." (*James Ward*)

This overview seeks to bring together the philosophies and aspirations that were expressed during the conference, and place them in an historical context. Selected key statements made by the speakers at the plenary sessions have been identified and reproduced with the overview, to emphasise what is perceived to be the collective viewpoint of those who participated in this Eighth Annual Seminar in Special Education.

The concept of a number of disciplines being involved in the care and treatment of children has been promoted for many decades, and many proposals have been put forward about the roles and functions of the various disciplines in health, education and welfare programs. While progress in this area has been made in a number of treatment areas, in that persons with differing disciplinary backgrounds work together in a complementary way in activities of assistance to children and adults, moves towards realistic collaborative interdisciplinary involvement have been rather slow.

Many people still express the view that although the concept of true interdisciplinary effort is a worthwhile one, it is really a "pipe-dream" and will never happen. Indeed it seems too easy for us to look at the present training and orientation of the various professions as being the source of difficulty in achieving interdisciplinary involvement in treatment, rather than actively seeking to find ways by which cooperative involvement can become a reality.

However, it still seems to be true to say that the contribution of each discipline and professional group must be integrated within the total treatment plan of a handicapped child, if that child is to receive the full benefit of advances in knowledge and skill. No discipline should take the view that the management of handicap is based in itself alone, and thus deny the contribution of other

"There is no place for the prima donna. The team approach is all important." (*Barry Appleton*)

disciplines. This narrow view typically leads to professional egotism, with resultant disadvantage to the handicapped child. A preoccupation with professionalism may also militate against professional functioning.

"One has no desire to produce jacks of all trades; but there is a very great need for all to have sufficient knowledge to make communication between the specialities effective." (*Helen Connell*)

Much of the current difficulty in advancing interdisciplinary involvement can be attributed to the educational world. Special education contributes most of the treatment meted out to handicapped children, but is typically as restrictive as other disciplines when it comes to interdisciplinary involvement. Special education generally concedes the contribution of others in the assessment and/or diagnostic functions of education but, too often, in little beyond that.

Origins of special education practice

At this stage an excursion into the common backgrounds of health, education and welfare progress will be useful.

Not many decades ago services to children in these areas were not readily identifiable from each other. For example, early health services to disadvantaged children also had a strong welfare component, in that they were as much concerned with the social circumstances of the patient as with adverse medical conditions. Likewise, early education programs for children with handicapping conditions were established within a welfare framework, in which the social care of the children was more important than education and training, with basic education and vocational skill training being added later in the development of these services. It can also be noted that much of early special education practice was influenced by medically *cum* psychologically trained persons.

"If we are to face our tasks with vision and with aims greater than plugging up individual holes in a dyke, our disciplines must cross-fertilize." (*Simon Latham*)

With the development of increasing specialization in the broad disciplinary areas of health, education and welfare, and their diversification into the wide range of professional groups which today are involved in services to children, we can also identify a trend for them to grow apart. Increasing knowledge, skill development, theoretical viewpoints, and service innovations have in many cases created a schism between disciplines, and a tendency for each to work in increasing isolation from the others.

"....efficient communication between disciplines involved with the welfare of the child is essential in order to further his interests...." (*Helen Connell*)

"The caring professions cannot work in isolation. The variety of skills required come from a variety of professions, and there is no exclusive territory." (*Geoffrey Swan*)

There have been some restraining influences on this trend. One of the most important of these can be seen in the development of school medical services; a 'traditional' link between medical and educational practice since the late 1800s in Europe, and the early 1900s in Australia. But even with such specific links between the disciplines as school medical services, the trend has still been toward separation of practice and provisions, rather than integration. This has led in recent years to a timely review of the role of medical services in schools, as reflected in the report of one working party at this conference.

The early contribution of medical services to special schooling

Many of the pioneers of special education, including Itard, Seguin, Guggenbuhl, Montessori, Decroly, and Binet, who contributed to early educational programs for the deaf or mentally retarded, were medical-psychological practitioners. But medical developments also contributed to the education of the handicapped in other ways.

"...important as it is to solve the dilemmas of the team approach in delivery of special services to those who need them, it is even more important to effect collaboration to ensure the provision of general living conditions which will minimize the need for special services." (*Edna Chamberlain*)

During the 1700's hospitals and dispensaries were founded, mainly by charity and private philanthropy. These institutions not only extended medical care to handicapped persons but helped make the communities of the period aware of their condition and needs. Epidemics which swept parts of Europe in the 1800's also placed an emphasis on health needs, and the necessity for the medical profession to systematise its knowledge and practice in such a way as to help combat the spread and effects of disease, including prevention of loss of life.

During the nineteenth century medical enquiry increased very rapidly. In the United Kingdom this included enquiry into the health and living conditions of the population, with emphasis on the "lower classes". Mortality rates, elimination of disease, the comparative health risk for various groups in society, improvement of diet and sanitation, all were extensively studied. The vigorous demands of public-spirited men such as Chadwick, who initiated the first report on the

Health of Towns in 1838, and was largely responsible for the Report on Intra-Mural Interments, ensured that the medical profession came to grips with the spread of epidemic disease, especially cholera. We also find freelance medical enquiry into defective eye-sight, including short-sightedness and the effects of school conditions on vision, during this period.

Local government authorities in the United Kingdom were made responsible for child welfare and the controlling of infectious diseases in schools; which mainly took the form of general improvement in sanitation and health standards, and later led to regulations on school closure. By 1884 medical officers were well established in schools and institutions. Advances in medical science during the last part of the nineteenth century led to a better understanding of nutrition and bacteriology, shorter working hours and greater leisure time and the development of X-ray techniques. Nevertheless, these advances, welcome and timely as they were, still left much to be accomplished in the twentieth century.

"History gives no grounds for complacency about our management of children. The social, family and disease pressures on children today may be different from those of yesterday, but are certainly no less troublesome for the child." (*Helen Connell*)

School medical services

The first school medical officer in the United Kingdom was appointed in 1890, in London, but with little emphasis on working with children. With the appointment of a medical officer at Bradford in 1893 emphasis was placed on the examination of children, which by 1906 had been instituted in 49 local education authorities. In comparison, medical inspection of school children began in Western Australia in 1906 and in Victoria in 1910. The duties of medical officers in the United Kingdom at this time ranged from anthropometric surveys to the examination of defective and epileptic children. Malnutrition was still widespread, and by far the greatest contributing factor to physical defects in children.

By 1907 the first Chief Medical Officer had been appointed by the Board of Education in London (later the Ministry of Education and Science), resulting in the continuing development of a school medical inspection system, oversight of school sanitation and of efforts to control infectious

diseases. At this time we also find medical officers being given the responsibility to notify the local education authorities of all children found to be defective, in the sense that special education was desirable (the terms mentally or physically defective were used in this period). This notification function for medical officers was to set a pattern which can still exist today, although it is frequently modified in administrative practice.

Newman, who as Chief Medical Officer was largely responsible for moulding the school medical service, and influenced many other aspects of special education practice in the United Kingdom, claims that the medical inspection of school children -

1. gave a picture of the physical condition of the nation's children, leading to treatment and the checking of childhood diseases;
2. stimulated parent interest in their children's health;
3. enhanced attention to pupil individuality, and
4. drew the teachers' attention to pupils' mental and physical aptitudes.

The medical inspection service also drew attention to speech defects, delicate pupils, and to partially sighted and partially deaf children, for whom classes commenced around 1910. Early checks on the vision of school children further drew attention to "congenital word blindness", largely from Kerr's work at Bradford.

Butterfield suggests that medical inspection accelerated the movement toward the establishment of recognized qualifications for teachers of the blind and deaf, in that the years 1907 to 1911 saw negotiations with existing schools, associations and teacher training colleges toward that end. He further suggests that it contributed to experimentation on teaching procedures in special schools.

Interface of education with welfare

In listing welfare as the third of the three disciplines brought together in this seminar, we

could be accused of having subscribed, albeit unconsciously, to the view that welfare is less *professionally* significant to children in need of help. Yet we have done no worse than the United States Government in setting up their Department of Health, Education and Welfare; and it would seem from Edna Chamberlain's paper that we have, at least, exhibited a greater degree of "togetherness".

Qualified social workers are a more recent addition to the group of professions working with disadvantaged children than most others working within the framework of Health or Education services. This may explain why it has been harder for qualified people, working within the broad boundaries of what is called social welfare, to achieve full recognition of their professional status. The shadow of nineteenth century philanthropy hangs more heavily over them than over those who work in medical, para-medical and educational settings. There is still confusion, both in the general public's perception, and at the point where services are offered to those in need, as to who is an untrained volunteer and who is a qualified professional in this area.

"The expressed values and goals of medicine, education and welfare are strikingly similar." (*Edna Chamberlain*)

All three disciplines represented in the title of this seminar do, in fact, "profess" to have the welfare of the child as a central aim in their activities. That they would better achieve this by closer collaboration can scarcely be denied. Increasing involvement with what is happening within each discipline, accelerated as it is today by ever-increasing specialization, tends to work against healthy cross-fertilization. The greatest need is that people working within their own disciplines should develop an awareness and the necessary skills which would enable them to communicate with others - across disciplines - who genuinely have the common aim of furthering the wellbeing of children in need.

"Collaboration demands more than anything else, interpersonal skills." (*Edna Chamberlain*)

It may well be that social workers could come to the fore in showing the way to all of us; for it is inherent in their training that they should be sensitive to other people's needs, and self-effacing in displaying their own. All disciplines could benefit from an interaction of this kind.

"....although parliamentary) acts and regulations often have good intentions and provisions, the enactment and administration of these does not fill out the promise of legislation." (*Geoffrey Smiley*)

"There remain large areas where welfare, education and the law should get together in an effort to achieve at least parallel development and approach rather than each of us going ahead on our own individual courses." (*Don Smith*)

"Social work students are taught no law." (*Quentin Bryce*)

"Lawyers are not trained in the behavioural sciences." (*Lynne Foreman*)

"The parent role is that terribly important one of *being a parent*, not a teacher's aide nor a therapist's aide, but a parent with a unique relationship with a child." (*Geoffrey Swan, Second Keynote Address*)

The interests of the child shall be paramount

In the Foreword to this publication, the Honourable, the Minister for Education stresses the need for the interests of the child to be paramount in Medicine, in Education and in Social Welfare. It was, however, a fourth discipline that particularly focussed the attention of this conference on this paramount issue - the Law. At one plenary session, a lawyer and two social workers discussed legislation as it relates to children; and it was the inadequacies rather than the adequacies of such legislation that received most attention. And the now familiar call for more effective communication across disiplines was sounded again.

At a public meeting held during the conference, two speakers with legal training expressed two rather different viewpoints on the issue of paramountcy (Chapters 6 and 7). It is of interest to note that both speakers commented on the encapsulation of disciplines from opposite directions. Here, at least, was one point of near agreement.

Parents and the Professions

In most seminars organized by professional people concerned with children's well-being parents tend to be under-represented. They could have been at this seminar had it not been for the inclusion in the program of the twelve working parties and workshops. Many parents feel unable to express their real thoughts and feelings when faced by a large number of professional people. It might be that the attitudes of many professionals have conditioned them to feel inadequate. This is a great wrong that must be rectified; for the parent's role is the most central of all to the well-being of the child.

The Working Parties and Workshops

We have seen, in Section Two of this publication, that each of the twelve working party/ workshop groups made recommendations for upgrading

services for handicapped children in the particular area to which they addressed themselves. It is, therefore, of interest to note that some communality of demand can be perceived when a "birds-eye view" of all twelve sets of recommendations is taken.

Eight of the groups suggest, in strongest terms that the disciplines concerned with health, education and welfare should learn more from one another and find more effective ways of communicating and cooperating. Six of the groups - either explicitly or implicitly - ask for more efficient and/or more widespread delivery of services to meet the needs of handicapped children. Five groups were emphatic in their suggestions that planning procedures for future development need considerable improvement. Three groups gave clear expression to the need for more responsiveness by professional persons to their clients. Two groups expressed a desire to see more attention paid to the socially handicapped than is, at present the case.

It needs to be said that when a conference makes provision for a cross-section of clients and professional people to gather in a forum, a good estimate of current feeling and opinion is immediately available. The best possible outcome would be accelerated implementation of the most urgent needs expressed in these recommendations. And if this be too much to hope for, nothing but good can result from groups of people with strong common interests meeting and reinforcing one another in their desire for a world that is fairer and brighter for handicapped children.

"Compelling scientific evidence sometimes takes years to obtain; meanwhile, the handicapped child and his parents need help today." (*Win Apelt and Robert Andrews*)

List of Contributors

ANDREWS, Dr. Robert J., Acting Director, Schonell Educational Research Centre, St. Lucia.

APELT, Miss Winifred C., Lecturer, Schonell Educational Research Centre, St. Lucia.

APPLETON, Dr. D.B., Visiting Neurologist, Royal Children's Hospital, Brisbane.

BRYCE, Mrs. Quentin, Senior Tutor, Department of Law, University of Queensland, St. Lucia.

CHAMBERLAIN, Professor Edna, Head of Department of Social Work, University of Queensland, St. Lucia.

COCHRANE, Mrs. Kathleen J., Senior Tutor, Schonell Educational Research Centre, St. Lucia.

CONNELL, Dr. Helen M., Senior Lecturer in Child Psychiatry, University of Queensland, St. Lucia.

FOREMAN, Mrs. Lynne, Lecturer, Department of Criminology, University of Melbourne.

HASKELL, Dr. Simon, Senior Lecturer in Special Education, Burwood State College, Victoria.

LATHAM, Dr. Simon, Deputy Medical Superintendent, Royal Children's Hospital, Brisbane.

MITCHELL, Dr. David R., Senior Lecturer in Education, University of Waikato, New Zealand.

SMILEY, Mr. Geoffrey, Director of Court Counselling, Family Law Courts, Brisbane.

SMITH, Mr. D.A.C., Principal Care Officer, Residential Care Services, Children's Services Department, Queensland.

SWAN, Mr. Geoffrey, Inspector of Schools (Special), Department of Education, Queensland.

WARD, Professor James, Professor of Special Education, Macquarie University, Sydney.

Group Leaders and Key Persons are listed in the body of the report (Section Two).